BRIAN

KIRK

Asheville Physical Therapy™

Orthopedics • Sports Medicine • Sports Performance

Initial Evaluation Appt. Date/Time

Patient Demographic Information

Patient Information -			
Name:		Primary Phone:	
Address 1:		Work Phone:	
Address 2:		Cell Phone:	
City:		Email Address:	
State:		Birth Date:	
Zip Code:		Employer:	

Emergency Contact (if under 18 years old parent or guardian to complete)			
Name:		Home Phone:	
Address:		Cell Phone:	

Referral Information - **Written referral Yes / NO** *(if no, Must have Primary Physician Name if Medicare)*			
Referring		Primary Care	
Reason for Visit:		Physical or Speech Therapy Elsewhere:	*Yes or No (Yes how many visits_____)*
Date of Surgery:		Surgeon:	
Surgery Notes		Received:	
Case Manager:		Authorization:	Yes or No

Primary Insurance			
Insurance Name:		# of Visits per Year:	
Insurance ID:		# of Visits Used:	
Policy Number:		Effective Date:	
Policy Holder: (Exactly as it appears on card)		End Date:	
Policy Holders DOB:		Relationship to Insured:	*Self / Spouse / Child / Other*

Secondary Insurance	
Insurance Name:	
Insurance ID:	
Policy Number:	

If minor child, must have Guarantor: _____ (printed)

(Must be a parent or legal guardian) _____(signed)