# 3 Dimensional Physical Therapy

A Division of IPTA Clinical, LLC

Patient name _____ DOB _____ Age _____

Address _____

City _____ State_____ Zip _____ Email _____

Phone _____ home/ cell/work Alt. Phone _____ home/ cell/work

SSN_____/_____/_____

Emergency contact _____ relationship _____

Emergency contact phone number _____ home/ cell/ work

Primary Care Physician name_____ Phone _____

Referring physician name _____ Phone _____

How did you hear about 3DPT:

Physician referral Internet search Insurance website Social media Friend/ family

(please specify) _____Other _____

Is this injury related to a motor vehicle accident? _____ yes _____ no if yes, give date _____

Is this injury related to a work accident? _____ yes _____ no if yes, please give date _____

Is this injury related to a school accident? _____ yes _____ no if, yes please give date _____

Have you obtained any school insurance documents? ___yes ___no

Do you have a secondary insurance policy _____ yes _____ no

Are you covered under any other healthcare plan _____ yes _____ no