Canyon Physical Therapy & Aquatic Rehabilitation
2852 N Navajo Dr. Suite A • Prescott Valley, AZ 86314

Patient Name _____ DOB _____ Age _____
Mailing Address _____ Apt. #_____
City_____ State_____ Zip Code_____ Phone _____
SSN_____ Marital Status S M D W
Employer_____ Occupation _____
Referred By_____ Primary Care Physician_____
e-mail _____

Is this related to an auto or any other accident, example: slip & fall? _____
Do you have an attorney involved?_____
Is this an Industrial (work related) injury?_____
(If applicable please complete information at bottom)

Spouse, Parents, or Emergency Contact

Name_____ Relationship _____ Phone _____

_____ _____
Patient/Responsible Party Signature **Date**

INSURANCE
SOME INSURANCE PLANS WILL ONLY ALLOW TREATMENT AS PERSCRIBED BY YOUR PHYSICIAN*

Primary Insurance_____

Secondary Insurance_____

Please complete appropriate insurance information for Workers' Compensation Case.
Industrial Carrier_____ Contact Person _____
Phone_____Claim #_____ Date of Injury _____
Employer at Time of Injury _____
Address _____City_____State_____ Zip_____
Contact Person _____ Phone _____

Please complete appropriate information for accident, slip & fall or any incident where an attorney is involved.
Auto Insurance Co._____Policy # _____
Address _____City_____ State_____ Zip _____
Contact Person _____ Phone _____
Name of Policy Holder_____Claim # _____
Date of Accident _____ Do you have an attorney _____
Attorney Name _____ Phone_____