

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 _____
Address _____
City _____ State _____ Zip Code _____ Work Phone _____
Referred By _____ Primary Care Physician _____
e-mail _____

Is this an Industrial (work related) injury? _____
Is this related to an auto or any other accident, slip and fall or any incident where an attorney is involved? _____

Spouse, Parents, or Emergency Contact

Name _____ Relationship _____ Phone _____
Address _____
City _____ State _____ Zip Code _____ Work Phone _____

INSURANCE

Primary Insurance _____ ID# _____ Group# _____
Name of Policy Holder if other than patient _____ SSN of policy holder _____
Policy Holder DOB _____

Secondary Insurance _____ ID# _____ Group# _____
Name of Policy Holder if other than patient _____ SSN of policy holder _____
Policy Holder DOB _____

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 insurance 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 _____

Patient/Responsible Party Signature

Date