

**Health-Pro Physical Therapy, Inc.**  
110 La Casa Via, Suite 100, Walnut Creek, CA 94598  
Phone: 925-935-4866 Fax: 925-935-8873  
www.HealthProPT.com

PLEASE PRINT

Today's Date: \_\_\_\_\_

Patient's Name _____		Home #: (____) _____	
E:mail Address _____		Cell #: (____) _____	
Address: _____		Date of Birth: ____/____/____	
City: _____	State: _____	Zip: _____	SS#: _____
Patient Status: (please circle) Single Married Widowed Divorced Separated			
Age: _____	Sex: _____	Employed _____	F/T student _____ P/T student _____
Employer: _____		Occupation: _____	
Address: _____		Phone: (____) _____	
City: _____	State: _____	Zip: _____	
Emergency contact: _____		Relationship: _____	
Phone: (____) _____	Address: _____		

Reason for Therapy: (please circle) Work Auto Home Other (Explain)
Date of Injury: ____/____/____ Adjustor if applicable: _____
Worker's Comp/MVA Claim #: _____ Adjustor Phone: _____

Referring Doctor: _____	Diagnosis: _____
Doctor Address: _____	Phone: _____
Date of Surgery: (if applicable) _____	Type of Surgery: _____

Insurance Company Name _____	Phone: (____) _____
Group #: _____	Policy #: _____ Medicare #: _____

How did you hear about Health-Pro Physical Therapy? \_\_\_\_\_

If referred by an individual, may we thank him or her? Yes No (Name/Phone #) \_\_\_\_\_

How did you find our phone number? \_\_\_\_\_

**I certify that the above information is true and correct to the best of my knowledge.**  
**I will notify this office of any changes in my status or the above information.**  
**I understand that 24 hour notice is required for cancellation of appointments.**  
**I understand that there will be a \$25 charge for missed appointments without prior notice.**

**I acknowledge that I have read and signed the privacy notice and Welcome Letter/Policies.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Please give your insurance card(s) and photo ID to the receptionist so we can make a copy for your file.