Welcome to Orthopedic Physical Therapy Center, LTD.

Name: _____ Home Phone: _____
First Middle Last

Address: _____ Work Phone: _____
Street Address/PO Box

_____ Cell Phone: _____
City State Zip Code

Birthdate: _____

Sex: ( ) Male ( ) Female Email: _____

Employer's Name: _____ Address: _____

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed

If married: Spouse's Name: _____
Employer's Name: _____

MVA/Car Accident: ( ) Yes ( ) No Work related injury: ( ) Yes ( ) No
Describe injury/condition: _____
Describe how injury occurred: _____
Date of injury/onset: _____

Billing Information
Responsible party: _____ Phone: _____
Address: _____
Street Address/PO Box City State Zip Code
Medicare Number: _____ Medicaid Number: _____
Primary Insurance Company Name: _____
Address: _____
Policy Number: _____ Group Number: _____
Claim Number: _____ Phone Number: _____
Name of insured: _____ Birth Date: _____

My medical and/or billing information may be shared with the following individuals. (This remains in effect until further notification from patient or authorized person). The doctor or facility that referred you automatically receives information about you.

_____ No, at this time I decline to add an authorized person.

Name _____ Relationship _____

Name _____ Relationship _____

Signature: _____ Date: _____

Orthopedic Physical Therapy Center
6 N. Roosevelt St. • Aberdeen, SD 57401 • Phone: (605) 725-9900 • Fax: (605) 725-9902