P·E·A·K
PHYSICAL THERAPY CENTER

Performance Enhancement & Kinetic Physical Therapy
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Tel. 760.230.5432 • Fax 760.655.4336
www.peakptc.com

Patient Information

PATIENT NAME		*DATE*
ADDRESS		
CITY	*STATE*	*ZIP*
HOME #	*CELL #*	*WORK #*
	DATE OF BIRTH	*AGE*
EMPLOYER	*OCCUPATION*	*M.D./DOCTOR*

Is problem due to an auto or workplace accident?

Person responsible for charges (if other than yourself)

RELATION		
ADDRESS		
CITY	*STATE*	*ZIP*
DATE OF BIRTH	*EMPLOYER*	
HOME #	*CELL #*	*WORK #*

Is it OK to leave message at above number? ○ Yes ○ No

Insurance Information

POLICY HOLDER (IF OTHER THAN YOURSELF)		*DATE OF BIRTH*
ADDRESS		
CITY	*STATE*	*ZIP*
PHONE #		*EMPLOYER*

Emergency Contacts (One that does not reside with you)

NAME	*RELATIONSHIP*	*PHONE #*
NAME	*RELATIONSHIP*	*PHONE #*
EMAIL		

How did you hear about us? (Please check all that apply)

○ Physician Referral ○ Friend ○ Other ○ Advertisement ○ Online

Name of Referral

NAME