



STAR Physical Therapy & Performance Training

Strength Training And Rehabilitation

13231 N. 35th Avenue Suite A-2
Phoenix, AZ 85029
Phone: (602) 896-1312
Fax: (602) 896-4311
www.star-pt-fitness.com

PATIENT INFORMATION: (Please print clearly.)

First Name: _____ MI: _____ Last Name: _____ Social Security#: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ DOB: _____ Age: _____

Female Male Married Single Other E-Mail Address: _____

Employer: _____ Address: _____

City: _____ State: _____ Zip: _____ Work Phone: _____

Emergency Contact: _____ Phone#: _____ Relationship: _____

RESPONSIBLE PARTY INFORMATION (IF OTHER THAN PATIENT):

Name: _____ Social Security#: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ DOB: _____ Age: _____

Female Male Married Single Other Relationship to Patient: _____

Employer: _____ Address: _____

City: _____ State: _____ Zip: _____ Work Phone: _____

PRIMARY CARE, REFERRAL INFORMATION:

Primary Care Physician: _____ Phone #: _____ Fax #: _____

Address: _____ City: _____ State: _____ Zip: _____

Referring Physician (if not PCP): _____ Phone #: _____ Fax #: _____

Address: _____ City: _____ State: _____ Zip: _____

How did you hear about us? _____

INSURANCE INFORMATION (If this is a workman's comp injury the carrier information must be provided as the primary insurance):

PRIMARY Insurance: _____ SECONDARY Insurance: _____

Phone #: _____ Phone #: _____

ID #: _____ Group #: _____ ID #: _____ Group #: _____

Insured Name: _____ Insured Name: _____

Insured Employer: _____ Insured Employer: _____

Insured DOB: _____ Insured DOB: _____

Relationship to patient: _____ Relationship to patient: _____

REASON FOR VISIT:

Is your injury a: Worker's Comp Injury. Auto Accident. Date if injury: _____ Body part: _____ Right / Left

Please tell us about your injury / condition, how you got hurt, symptoms, etc.: _____

