



STAR Physical Therapy & Performance Training
Strength Training And Rehabilitation

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Phoenix, AZ 85029
Phone: (602) 896-1312
Fax: (602) 896-4311
www.star-pt-fitness.com

PATIENT INFORMATION:

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

