Patient Information

Elite Therapy, P.C.
285 South Main St.
Mansfield, PA 16933
(570) 662-1400
Fax: (570) 662-1401

Patient Name:_____ ◊ Male ◊ Female

Parent or Guardian Name (if applicable):_____

Address:_____

City:_____ State:_____ Zip Code:_____

Patient Social Security No.:_____ Date of Birth:_____

Home Phone: _____ Cell Phone:_____

Marital Status: ◊ Married ◊ Single ◊ Other Student Status: ◊ N/A ◊ Full-Time ◊ Part-Time

Emergency Contact: _____ Phone:_____

Employment Status: ◊Full-Time ◊Part-Time ◊Retired ◊Not Employed

Name of Employer (if applicable): _____

Address: _____ Phone: _____

City:_____ State:_____ Zip Code:_____

Was your injury related to work? (current or previous): YES NO Was your injury related to a car accident? YES NO

INSURANCE INFORMATION: Are you the Guarantor/Insured or is your policy under another person?
Yes, I am the Guarantor/Insured or

No, the Guarantor/Insured name is: _____ ◊ Male ◊ Female
Your relationship to the Guarantor/Insured is: ◊ Spouse ◊ Child ◊ Other

Guarantor/Insured address:_____

City:_____ State:_____ Zip Code:_____

Guarantor/Insured Phone: _____Guarantor/Insured date of birth: _____

Guarantor/Insured Employer: _____

Primary Health Insurance Plan:_____

Insurance ID Number:_____Group Number:_____

Secondary Health Insurance Plan: _____

Insurance ID Number:_____Group Number:_____

Please give the receptionist your insurance card (s) for copying