

**Ultimate Therapy**  
**40900 Merchants Lane, Suite 202**  
**Leonardtown, MD 20650**

**Patient Information**

\_\_\_\_\_  
Last Name                      First Name                      Age                      Sex M F

\_\_\_\_\_  
Street Address                      City                      State                      Zip

(\_\_\_\_\_) (\_\_\_\_\_) \_\_\_\_\_  
Home Phone                      Cellular                      Email Address

\_\_\_\_\_  
Occupation                      Employer Name                      Phone #

\_\_\_\_\_  
Emergency Contact Person                      Phone #                      (if minor) Parent/Guardian Name and Signature

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status: S M D W

Work Status:  currently employed  retired  disabled ( \_\_ total or \_\_ temporary)  student \_\_PT \_\_FT

How did you hear about us? \_\_\_\_\_

**Medical Information**

\_\_\_\_\_  
Referring Physician                      Phone                      Fax

\_\_\_\_\_  
Referring Physician Street Address                      City                      State                      Zip Code

Injury \_\_\_\_ Illness \_\_\_\_ Accident \_\_\_\_ Date of onset \_\_\_\_\_

**Payment Information**

I am paying by:  
\_\_\_\_ self pay  
\_\_\_\_ Bill my insurance directly My copay/coinsurance is \$\_\_\_\_. My deductible is \$\_\_\_\_.

**Primary Insurance**

Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Subscriber Address: \_\_\_\_\_  
Insurance Name: \_\_\_\_\_ Policy# \_\_\_\_\_ Group# \_\_\_\_\_  
Relationship to Patient: \_\_\_\_ self \_\_\_\_ spouse \_\_\_\_ parent

**Secondary Insurance**

Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Subscriber Address: \_\_\_\_\_  
Insurance Name: \_\_\_\_\_ Policy# \_\_\_\_\_ Group# \_\_\_\_\_  
Relationship to Patient: \_\_\_\_ self \_\_\_\_ spouse \_\_\_\_ parent

**Office Use Only**

NPI \_\_\_\_\_ Diagnosis Codes: \_\_\_\_\_; \_\_\_\_\_; \_\_\_\_\_; \_\_\_\_\_