

New Patient Information

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

City/State/Zip: _____ E – Mail Address: _____

Employer: _____ Phone: _____

Address: _____ City/State/Zip: _____

Date of Birth: _____ Age: _____ Sex: _____ Soc. Sec. #: _____

Person to notify in Emergency: _____ Phone: _____

Relationship: _____ Marital Status: Married / Single / Widowed / Divorced / Separated
(circle one)

Referring Physician: _____ Family Physician: _____

If someone other than the Referring Physician and/or the Family Physician referred you to our office, please indicate the name: _____

Spouse's Name: _____ Soc. Sec. # _____ Date of Birth: _____

(If patient is under 18 years of age, please complete below:)

Guarantor/Responsible Party Name: _____ S.S.#: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Insurance Information – Commercial Insurance / Medicare / Other: _____
(circle one)

Workers' Comp / Auto Accident Date of Injury: _____

Have you had any of the following therapies/services before? (check all that apply)

Physical Therapy year: _____ # visits _____ Chiropractic year: _____ # visits _____

Occupational Therapy year: _____ # visits _____ Cardiac Rehab year: _____ # visits _____

Speech Therapy year: _____ # visits _____ Vision Therapy year: _____ # visits _____

Have you received any home health care / home therapy? year: _____ # visits _____

Primary Insurance to be Billed: _____ Phone: _____

Group # (Corporate #): _____ Policy # (Individual #): _____

Insured Party's Name: _____ S.S. #: _____ Date of Birth: _____

Insured Party's Employer: _____ Contact Person for Insurance: _____

Precertification Required: Yes No (circle one) Referral Slip Required: Yes No (circle one)

Please indicate any additional health insurance below: (If primary Insurance is Workers' Comp, MVA, Slip & Fall, provide your personal insurance below in the event of denial or maximum benefit met.)

Secondary Insurance: _____ Phone: _____

Group (Corporate #): _____ Policy # (Individual #): _____

Insured Party's Name: _____ S.S. #: _____ Date of Birth: _____

Insured Party's Employer: _____ Contact Person for Insurance: _____