

Therapist: \_\_\_\_\_ DT / SH First Appt. Date \_\_\_\_\_

New Patient  Return Patient

Patient Name: \_\_\_\_\_  
Last First M.I.

Address: \_\_\_\_\_  
Street or P.O. Box City State Zip

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female SS#: \_\_\_\_\_

Patient status:  Single  Married  Widowed  Other

Person Financially Responsible: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship: \_\_\_\_\_

**ADDITIONAL INFORMATION: (required)**

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_  Retired

Address: \_\_\_\_\_ Job Description: \_\_\_\_\_

Are you a student?  Yes  No  Full time  Part time

**INSURANCE INFORMATION (required)**

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

Policy #: \_\_\_\_\_ Policy#: \_\_\_\_\_

Group #: \_\_\_\_\_ Group#: \_\_\_\_\_

Is patient the subscriber?  Yes  
 No, please fill out below

Is patient the subscriber?  Yes  
 No, please fill out below

Subscriber Name: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Social Security # \_\_\_\_\_

Social Security # \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Relationship: \_\_\_\_\_

Relationship: \_\_\_\_\_

**Doctor/ Emergency Contact (required)**

Referring Doctor: \_\_\_\_\_  
First Last Name

Primary Care Doctor: \_\_\_\_\_  
First Last Name

Date Last Seen: \_\_\_\_\_

Date Last Seen: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

**INJURY OR ONSET OF PAIN INFORMATION (required)**

ILLNESS  INJURY Date of injury/Onset of symptoms \_\_\_\_\_

What body part is involved \_\_\_\_\_  Right  Left

Injury Occurred:  Home  Employment  School  Recreation  Pedestrian  MVA/Auto

State of Occurance: \_\_\_\_\_ PIP Claim # \_\_\_\_\_

Insurance Adjusters Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

Attorney: \_\_\_\_\_ Phone#: \_\_\_\_\_

Attorney Address: \_\_\_\_\_

Receptionist Initials: \_\_\_\_\_