

Focus Physical Therapy + Fitness

New Patient Information Sheet

Welcome to our practice!

Please help us serve you better by taking a few minutes to provide the following information.

1. PATIENT INFORMATION

Social Security #	Title	Last Name	First Name	MI
Street Address (Road or Street)			E-Mail Address:	
Zip Code	City	State		
Home Phone:	Cell Phone:		Work Phone:	
Birthday	Sex (M, F)	Referring Doctor full name & phone #		
Employment <input type="checkbox"/> R-Retired <input type="checkbox"/> F-Full <input type="checkbox"/> P-Part <input type="checkbox"/> N-None	Relationship to Insured <input type="checkbox"/> SE-Self <input type="checkbox"/> SP-Spouse <input type="checkbox"/> OT-Other <input type="checkbox"/> CH-Child	Do You Have a Prescription for Physical Therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Employer Name	Was your injury due to an auto accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please list the Auto Policy Claim # and contact person in Section # 4 below.			
How did you hear about us?				

2. INSURANCE INFORMATION

Primary Insurance Company Name	Mailing Address			
Insurance Telephone #	Policy #	Group #		
Secondary Insurance Company Name	Mailing Address			
Secondary Telephone #	Policy #	Group #		

3. COMPLETE IF INSURANCE IS IN YOUR SPOUSE'S or PARENT NAME

Social Security #	Title	Last Name	First Name	MI
Birthday	Sex (M, F)	Relationship to Insured:		

4. ACCIDENT DETAILS- Please complete if visit is due to your injury

Employment related: <input type="checkbox"/> Yes <input type="checkbox"/> No	Accident Related: <input type="checkbox"/> Auto <input type="checkbox"/> Other <input type="checkbox"/> No	Accident Claim #
Contact person and number for Auto or Work Related Accident:		

I authorize the release of any medical or other information necessary to process insurance claims.

I authorize payment of medical benefits directly to this practice for the services rendered.

Signed _____ Date _____

Signed _____ Date _____