PHYSICAL THERAPY PLUS
NEW PATIENT INFORMATION

*****No P.O. Box Addresses*****

Client Information:

Name: _____DOB: _____ Age: _____ ☐ Male ☐ Female

Address:_____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____ Work: _____

Employer: _____ **SSN:** _____

Email Address:_____

Your Referring MD:_____ Your Family MD_____

Date of your injury or surgery:_____ Was your injury due to: ☐ Auto Accident ☐ Work Injury ☐ Other

Have you had Physical Therapy Before? Y N If yes, when? _____ How long?_____

Responsible Party Information (Please fill out if client is minor)

Name: _____ DOB_____ SSN_____

Address: _____City _____State: _____ Zip: _____

Home phone: _____ Cell: _____ Work: _____

Emergency Contact:

Name:_____Relationship:_____Phone:_____

POLICY HOLDER INFORMATION:

Insurance Company: _____ Insurance ID # _____

Policy Holder Name: _____Policy Holder Date of Birth: _____

Policy Holder's Employer _____ Policy Holders SSN _____

Policy Holder address if different than client: _____

Client relationship to insured (please circle one): ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance:

Insurance Company: _____ Insurance ID # _____

Policy Holder Name: _____Policy Holder Date of Birth _____

Policy Holder's Employer _____ Policy Holders SSN _____

Policy Holder address if different than client: _____

Client relationship to insured (please circle one): ☐ Self ☐ Spouse ☐ Child ☐ Other

How did you hear about us? (check one) ☐ Physician ☐ Telephone book ☐ PT Plus Newsletter

☐ Friend/Relative ☐ Newspaper ☐ Website ☐ Other:_____

PLEASE RETURN THIS FORM WITH INSURANCE CARD AND PICTURE ID

Employee initial _____