

## PHYSICAL THERAPY

**\*\*\*CO-PAYS TO BE COLLECTED  
AT TIME OF VISIT\*\*\***

### NEW PATIENT INFORMATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_  
Street: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Employer: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Street: \_\_\_\_\_ Business Phone: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Referring Physician: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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Was this injury employment related? \_\_\_\_\_  
Was this injury due to a motor vehicle accident? \_\_\_\_\_  
Please provide billing information if claim is being processed through worker's compensation or motor vehicle insurance: \_\_\_\_\_

**Have you had physical therapy anywhere in the past 12 months?**

\*\*\*\*\*PLEASE PRESENT YOUR INSURANCE CARD FOR PHOTOCOPYING\*\*\*\*\*

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