NEW PATIENT INFORMATION SHEET

Patient's Name_____
(Last) (First) (Middle Initial)

Home Address:_____
(Address & Street) (City) (State) (Zip Code)

Home Phone#:_____-_____-_____ Mobile Phone#:_____-_____-_____ Sex: ☐ Male ☐ Female

Date of Birth:_____/_____/_____ Social Security Number:_____-_____-_____

E-mail Address_____

Referring Physician_____ Phone#:_____-_____-_____

Emergency Contact: _____Phone#:_____-_____-_____Relationship_____

How would you like to be reminded for you appointments: ☐ Email ☐ Phone Call ☐ Text

Are you being seen as the result of an auto accident related injury? ☐ Yes ☐ No

Have you received any physical, speech or chiropractic care this year? ☐ Yes ☐ No Visits used_____

Have you received Home Health Care services this year? ☐ Yes ☐ No Discharge Date____/____/____

MILITARY MEMBERS ONLY

☐ ACTIVE DUTY ☐ RETIRED

Sponsor'sName:_____
(Last) (First) (Middle Initial)

Relationship to Patient: ☐ Self ☐ Spouse ☐ Dependent Sponsor's Date of Birth:_____/_____/_____

Phone#:_____-_____-_____ Social Security Number:_____-_____-_____

INSURANCE INFORMATION:

Primary Insurance Company:_____ ID Policy #:_____

Policy Holder's Name:_____Relationship to Patient: ☐ Self ☐ Spouse ☐ Dependent

Second Insurance Company:_____ ID Policy #:_____

AUTHORIZATION TO BILL INSURANCE

I hereby authorize the release of information necessary to file a claim with my insurance company and to assign benefits otherwise payable to me to North Coast Physical Therapy. I authorize North Coast Physical Therapy to release and/or send medical information regarding my case to other consulting and/or referring physicians. I certify that the information I have reported with regard to my insurance coverage is correct.

_____ _____
Signature Date