



## ORTHOPEDIC & SPINE PHYSICAL THERAPY

## NEW PATIENT FORM

PRINT CLEARLY

Name (First) \_\_\_\_\_ (Last) \_\_\_\_\_ (MI) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Social Security \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex: M / F  
Email Address \_\_\_\_\_ Marital Status: M S D W

Employer \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_  
Full Time / Part Time / Not working / Retired / Student  
Emergency Contact \_\_\_\_\_ Telephone \_\_\_\_\_  
Referring Physician \_\_\_\_\_ Primary Physician \_\_\_\_\_  
Who may we thank for your referral? \_\_\_\_\_

Injury Type:  Work  Auto  Home  Other \_\_\_\_\_ Injury Date \_\_\_\_\_

Primary Insurance \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_  
Insured Name \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_  
Insured Employer \_\_\_\_\_ Address \_\_\_\_\_  
Secondary Insurance \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_  
Insured Name \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_

### Please Read and Sign:

I request that payment of authorized benefits be made to Orthopedic & Spine Physical Therapy, PC for any services furnished to me by the clinician. I authorize my holder of medical information needed to determine the benefits payable for related services about me be released to my insurance company and its agents. I permit a copy of this authorization to be used in place of the original.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I am aware that payments for self-pays/co-pays are due at the time services are rendered. I may also be responsible for any balances/co-insurance due after insurance payment is made.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I am aware that if I no show an appointment or do not call 24 hours ahead of my scheduled appointment I will be charged a \$10.00 FEE. If I miss three appointments reserved for me without calling to cancel I forfeit the rest of my scheduled appointments.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_