NEW PATIENT INFORMATION

Patient Name: ______________________ Soc. Sec. No.: ______________________

Date of Birth: ______________________ Marital Status: ☐ Single ☐ Married ☐ Divorced

Home Address: ______________________

City / State: ______________________ Zip Code: ______________________

Home Phone: ______________________ Work Phone: ______________________ Cell Phone: ______________________

Employer: ______________________ Occupation: ______________________

Whom should we Thank for recommending us? ______________________

COMPLETE THIS SECTION ONLY IF PATIENT IS COVERED UNDER SOMEONE ELSE'S INSURANCE -

Insured Name: ______________________ **Relationship:** ______________________

Ins. Soc. Sec. No: ______________________ **Date of Birth:** ______________________

Ins. Employer: ______________________

AUTO ACCIDENT

Date of Accident ______________________ Were you: _____ Driver _____ Passenger _____ Pedestrian

Describe Accident: ______________________

Insurance Name: ______________________ Phone No.: ______________________

Insurance Address: ______________________

Adjuster: ______________________ Policy/Claim No.: ______________________

JOB-RELATED INJURY

Date of Injury: ______________________

Describe Injury: ______________________

Employer Name: ______________________

Employer Address: ______________________

Adjuster: ______________________ Phone No.: ______________________

Insurance Name: ______________________ Claim No.: ______________________

Insurance Address: ______________________

OTHER INJURY

Date of Injury: ______________________

Describe Injury: ______________________

Are you covered by any group insurance policy? ______________________ YES ______________________ NO

Attorney Name: ______________________ Phone No: ______________________

Attorney Address: ______________________

INSURANCE AND TREATMENT AUTHORIZATION

I certify that the above information is true and correct. I authorize this office to provide Evaluation, Treatment and to release any medical information needed, to my insurance carrier or others, to submit a claim. I request that payment be made on my behalf and made to **A & A Physical Therapy Associates, Inc.** I also understand that I will be financially responsible for the balance not covered by my insurance.

Insured Signature: ______________________ **Date:** ______________________