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## NEW PATIENT INFORMATION SHEET

Welcome to our practice! Please help us serve you better by taking a few minutes to provide the following information.

| PATIENT INFORMATION   |           |  |  |                         |   |   |   |       |          |
|---|-----------|--|--|-------------------------|---|---|---|-------|----------|
| Title   | Last Name |  | First Name   |                         | MI  | Preferred Name                              |   |       |          |
| Address   |           |  |  |                         |   | Email                                       |   |       |          |
| City  |           | State  | Zip Code   |                         | Account #   |   | Social Security #   |       |          |
| Home Phone  |           | Cell Phone   |  |                         | Birthday  |   | Sex   |       |          |
| Referring Doctor (if applicable)  |           |  |  |                         | Primary Care Physician  |   |   |       |          |
| Marital<br><input type="checkbox"/> Married <input type="checkbox"/> Widowed<br><input type="checkbox"/> Single <input type="checkbox"/> Divorced<br><input type="checkbox"/> Separated         |           | Employment<br><input type="checkbox"/> Retired <input type="checkbox"/> Full Time<br><input type="checkbox"/> Part Time <input type="checkbox"/> Unemployed<br><input type="checkbox"/> Social Security Disability |  |                         | Student<br><input type="checkbox"/> Part Time <input type="checkbox"/> Full Time<br><input type="checkbox"/> Unemployed   |   | Relationship to Insured<br><input type="checkbox"/> Self <input type="checkbox"/> Spouse<br><input type="checkbox"/> Child <input type="checkbox"/> Other |       |          |
| Employer Name   |           |  | Employer Address   |                         |   | City  |   | State | Zip Code |
| Work Phone Number   |           | Extension  |  | Emergency Contact Name  |   |   | Emergency Contact Phone   |       |          |
| Receive Appointment Reminder<br><input type="checkbox"/> Phone <input type="checkbox"/> Email   |           |  |  |                         | Subscribe to Monthly Newsletter<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |       |          |
| INSURANCE INFORMATION   |           |  |  |                         |   |   |   |       |          |
| Primary Insurance Company Name  |           |  |  |                         |   | Secondary Insurance Company Name            |   |       |          |
| COMPLETE IF INSURANCE IS IN SPOUSE'S/PARENT NAME  |           |  |  |                         |   |   |   |       |          |
| Title   | Last Name |  | First Name   |                         | MI  | Social Security #                           |   |       |          |
| Birthday  |           | Sex  |  | Relationship to Insured |   |   |   |       |          |
| ACCIDENT DETAILS - PLEASE COMPLETE IF VISIT IS DUE TO INJURY  |           |  |  |                         |   |   |   |       |          |
| Employment Related<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |           |  | Accident Related<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                         |   | Date of first symptom or accident<br>/    / |   |       |          |
| Details of Accident   |           |  |  |                         |   |   |   |       |          |
| I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical benefits directly to this practice for the services rendered. |           |  |  |                         | I do hereby agree and give my consent for Cedar Hill Physical Therapy to furnish medical care and treatment which is considered necessary and proper in the evaluation and treatment of my condition. |   |   |       |          |
| Signed _____  |           |  |  |                         | Signed _____  |   |   |       |          |
| Date _____  |           |  |  |                         | Date _____  |   |   |       |          |