New Paradigm physical therapy

Patient Data Sheet

Please complete this form in its entirety prior to your first visit. Also, please bring your insurance information and/or cards to our office at your first visit. **It is the patient's responsibility to notify our office of any changes to your information listed on this form.**

PATIENT INFORMATION

Name: _____ (LAST) _____ (FIRST) _____ (MIDDLE)

Address: _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

Home# _____ **Work#** _____ **Cell#** _____

Email: _____ **Preferred contact method:** ☐ HOME ☐ WORK ☐ CELL **Sex:** ☐ MALE ☐ FEMALE

Date Of Birth: _____ ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ SEPARATED ☐ OTHER

Referring Physician: _____ **Primary Care Physician:** _____

Employer Name/Address: _____ (NAME) _____ (STREET) _____ (CITY, STATE, ZIP)

Emergency Contact: _____ (NAME/RELATION) **Phone:** _____

The above information pertains to the patient only. If the patient is a minor, then the responsible party completes the next section. If the patient is not a minor, then skip the next section.

RESPONSIBLE PARTY INFORMATION - Relation to patient: ☐ MOTHER ☐ FATHER ☐ OTHER

Name: _____ (LAST) _____ (FIRST) _____ (MIDDLE)

Address: _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

Home# _____ **Work#** _____ **Cell#** _____

Employer Name/Address: _____ (NAME) _____ (STREET) _____ (CITY, STATE, ZIP)

Date Of Birth: _____

INSURANCE INFORMATION: Are you aware of your benefits for your insurance? ☐ NO ☐ YES

Primary Insurance Name: _____ **Insured Name:** _____

Primary Insurance Address: _____ **Phone:** _____

Policy ID# _____ **Policy Group#** _____ ☐ **See Copy Of Card**

Secondary Insurance Name: _____ **Insured Name:** _____

Secondary Insurance Address: _____ **Phone:** _____

Policy ID# _____ **Policy Group#** _____ ☐ **See Copy Of Card**

ACCIDENT INFORMATION: Was this injury the result of an accident? ☐ **NO** ☐ **YES** **Date Of Accident/Injury:** _____

☐ **Motor Vehicle Accident** ☐ **Work Related** ☐ **Other**

CONSENT: By signing this form, I agree and give my consent for New Paradigm Physical Therapy, LLC to furnish physical therapy care and treatment considered necessary and proper in diagnosing and/or treating my physical condition(s).

Internet users: When document is completed, please re-save/print and bring in to your next appointment.

_____ **Signature**

_____ **Date**