NEW PATIENT INFORMATION SHEET

Patient Name: _____ Date:_____
Last First M.I.

DOB: _____

Address: _____ Male Female

Parent/Guardian (if patient is a minor):_____

Patient Home Phone #:_____Work/Cell #:_____

Social Security #: _____

Emergency Contact: _____Phone #: _____

Relationship to Patient: _____

Referring Physician Name: _____

Physician Phone #: _____Physician Fax # : _____

Injury Information

Date of Injury/Condition: _____Side Affected: ☐ Right ☐ Left ☐ Both

Body Region Affected _____

Insurance Information

Primary Insurance: _____ Contract/ID #: _____

Subscriber Name: _____ Subscriber DOB: _____

Group #: _____Insurance Provider Contact #: _____

Secondary Insurance: _____ Contract/ID #: _____

Mi Therapy Clinic

Subscriber Name: _____ Subscriber DOB: _____

Group #: _____Insurance Provider Contact #: _____

If Medicare, is the patient currently receiving Home Health Care Services?
(Nursing, therapy home health aide)

Has the patient had Physical, Occupation, or Speech Therapy this year?

Is the injury/condition an auto related accident?
If yes, please fill out the Auto/Workers comp section on page 2.

Is this injury/condition a work related accident?
If yes, please fill out the Auto/Workers comp section on page 2.

Auto / Workman's Compensation Patients Only

What State was the accident in? _____Is this an Open Claim? _____

Claim #: _____Insurance Company: _____

Address: _____Ins. Contact #:_____

Subscriber Name: _____Subscriber DOB: _____

Case Manager Name: _____Contact #:_____Fax #:_____

Case Adjuster Name: _____Contact #:_____Fax #:_____

Is the case currently under legal proceedings? _____

I certify that all the information provided is correct.

Patient Signature: _____Date: _____