Back To Normal Physical Rehabilitation
New Patient Information Form

==========Patient Information==========

Last Name:_____ First Name:_____ Middle Initial_____

Address Street:_____City_____State:_____ Zip:_____

Home Phone:_____ Cell #:_____ **DOB**_____ SSN_____

Employer: _____ Employer's Phone #:_____ Email _____

****Are you currently receiving Home Health Services:_____** Marital Status: Single Married Divorced Widowed

In case of emergency, contact _____ Phone#_____

==========Insurance Information==========

Policy Holder's relation to the patient: (Circle One) Self Spouse Parent/Guardian Other

Primary Insurance Co:_____ **Name of Insured**:_____

Address of Insured:_____ **DOB:**_____ SSN:_____

Insured's Employer:_____ Employer's Phone #:_____

Secondary Insurance Co:_____ Name of Insured:_____

Address of Insured:_____ DOB:_____ SSN:_____

Insured's Employer:_____ Employer's Phone #:_____

==========Other Information==========

Physician who wrote your prescription:_____Physican Phone #:_____

Diagnosis or Chief Complaint:_____**Date of Injury**/Date pain began: _____

Have you received physical/occupational/ speech/massage therapy during this calendar year? _____ # of visits:_____

If yes, which service and where? _____

==========Personal Injury Cases Only==========

Motor Vehicle Accident: (Circle One) Yes or No Work Related Injury: Yes or No Other: _____

Auto insurance Carrier/Attorney Name:_____ Phone#_____

Contact_____Address:_____

Claim#_____

Are you using med-pay? _____ How much do you have remaining? _____

Is this Worker's Compensation? _____ Insurance Carrier:_____ Claim#:_____

Contact Person:_____ Phone Number: _____

"I acknowledge that the information I have provided is true and correct, and that I am ultimately responsible for payment of all charges incurred for my therapy. I authorize Back To Normal to render treatment to me, understanding that there are possible risks associated with physical therapy treatment. I irrevocably authorize and demand the assignment of my basic medical, major medical, auto medical, third party medical or any other medical benefits that may apply, herein specified and otherwise payable to me, directly to Back To Normal. I have read and understood the statements contained herein."

_____ _____

Signature of Patient or guarantor (if not patient) Date