NEW PATIENT INFORMATION

Today's Date:______________________________ Date of Current Injury/Surgery:______________________________

Name: (First)______________________________ (Last)______________________________ (M.I.)__________

Home Address:____

City:______________________________ State:__________ Zip:______________________________

Best Phone#:____________________ 2nd Phone#:____________________ 3rd Phone#:____________________
cell | home | work   cell | home | work   cell | home | work

Social Security#:______________________________ DOB:____________________ Age:__________ Gender: ☐ M ☐ F

Email Address:____
(Your email will be added to our database, but it will not be shared or sold)

Status: ☐ Married ☐ Single ☐ Divorced ☐ Domestic Partner ☐ Separated ☐ Widowed

Emergency Contact:____________________ Relationship:____________________ Phone:____________________

Referring Physician:____________________ Specialty:____________________ Phone:____________________

Primary Care Physician:______________________________ Phone:____________________

Who may we thank for your referral other than your doctor?______________________________

Occupation:______________________________ Employment Status: ☐ Full-time ☐ Part-time ☐ Not working ☐ Student

Injury type? ☐ Recreation ☐ Home ☐ Work ☐ Auto Accident ☐ Unknown ☐ Other:______________________________

Insurance: (please circle all that apply) Personal Pay Health Insurance Auto Personal Injury Medicare

MEDICARE INFORMATION (please provide card)

Have you had any PT this year provided in your home or in another outpatient clinic? ☐ Yes ☐ No # of visits__________

Have you had speech therapy this year? ☐ Yes ☐ No Do you currently have Medicare home services? ☐ Yes ☐ No

Medicare ID:______________________________ Subscriber's name if different:______________________________

Other Insurance:______________________________ Subscriber's name if different:______________________________

COMMERCIAL INSURANCE INFORMATION (please provide card)

Insurance Company:______________________________ Phone:____________________

Subscriber Name: ______________________________ Relationship to Patient: ______________________________

Subscriber's DOB: ____________________ Subscriber's Employer: ______________________________

Subscriber's Employer Address: ______________________________ Phone:____________________

Insurance ID Number: ______________________________ Group Number:______________________________

By signing below, I agree that all of the above information is correct, and that I authorize HealthWell Physical Therapy Group to provide me with therapy services and to furnish my physician, insurance company or attorney information concerning my injury and treatment. I understand that I am financially responsible for payment of all charges that are not covered by (or paid for by) my insurance carrier. I understand I will be charged in full for any cancellations made less than 24 hours prior to my appointment. I understand that any patient balance exceeding 60 days will be billed to my credit card. Should my account be referred to collections, I will be responsible to pay the cost of collection, including legal fees.

Patient Signature (Parent/Guardian if necessary):______________________________ Date:____________________