Ann Mary Wilkinson PTMS, DOMTP
New Patient Information Form

Personal Information (All areas marked with a * MUST be completed)

*Patient's Legal Name: _____ Nickname: _____
First *MI* *Last*

*Patient's Home Address:

_____
Street *City* *State* *Zip*

*Patient's E-mail Address: _____@_____

Patient's Home Phone #: (_____)_____

Patient's Business Phone #: (_____)_____

*Patient's Main Cell Phone #: (_____)_____

Other Important Phone #: (_____)_____ *Type of # ?: _____

*Patient's Social Security #: _____-_____-_____

*Patient's Date of Birth: _____ /_____ /_____ Age: _____

*Patient's Gender (circle one): Female Male

*Patient's Martial Status (circle one): Single Married Other (Other includes Divorced, Widowed & Domestic Partnerships)

*Patient's School *OR* Work Status (circle only one): F/T Student P/T Student *OR* Employed Not Employed

Primary Insurance Information (All areas marked with a * MUST be completed)

*Insurance Company Name: _____

Insurance Company Phone #: (_____)_____

*Subscriber's Name (if different): _____

*Subscriber's Date of Birth: _____ /_____ /_____ *Relationship to patient: _____

*Subscriber's Employer: _____

*Subscriber's Insurance ID#: _____

*Subscriber's Group Policy/ID #: _____

*Subscriber's Phone # (if different): (_____)_____

*Subscriber's Address (if different):

_____
Street City State Zip

*Co-Payment Amount (Payment is required at appointment time): $_____

*Does the patient have an "Out-of-pocket deductible" for Physical Therapy? (circle one): Yes No

*Does the patient require a "Pre-Authorization" before Physical Therapy begins?(circle one): Yes No

Pre-Authorization Code (Provided by subscriber's insurance company): _____

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Family Information (All areas marked with a * MUST be completed)

Immediate Family Members :

*Spouse's Name: _____ Age: _____
First *MI* *Last*

Spouse's Employer: _____

Spouse's Business Phone #: (_____) _____

*Children/Siblings (First names & ages only):

_____ _____

_____ _____

*Other Extended Family Members Living With Patient:

Name: _____ *Relationship to patient: _____

Name: _____ *Relationship to patient: _____

Emergency Contact Information (All areas marked with a * MUST be completed)

*Name: _____ *Relationship to patient: _____

*Contact Phone #1: (_____) _____

*Contact Phone #2: (_____) _____

*Emergency Address:

_____
Street *City* *State* *Zip*

Secondary Insurance Information (All areas marked with a * MUST be completed)

*Insurance Company Name: _____

Insurance Company Phone #: (_____) _____

*Subscriber's Name (if different): _____

*Subscriber's Date of Birth: _____ /_____ /_____ *Relationship to patient: _____

*Subscriber's Employer: _____

*Subscriber's Insurance ID#: _____

*Subscriber's Group Policy/ID #: _____

*Subscriber's Phone # (if different): (_____) _____

*Subscriber's Address (if different):

_____
Street *City* *State* *Zip*

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Physical Health Information (All areas marked with a * MUST be completed)

*Does the patient have a Primary Care Physician(circle one): Yes No

*Primary Care Physician's Name: _____

*Primary Care Physician's Phone #: (_____) _____

*Is the patient currently experiencing any chronic physical issues or limitations (circle one): Yes No

Briefly explain any physical issues:_____

*Does the patient smoke or use tobacco products?(circle one): Yes No How much per day?: _____

*Does the patient drink alcohol regularly?(circle one): Yes No How many drinks per day?: _____

*Prescribed Physical Health Medications:

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

*I hereby certify that the subscriber listed in this document has active health coverage with _____ Insurance Company. My signature below is providing express consent to assign all insurance benefits from this company, in relationship to this treatment, otherwise payable to me, directly to_____.

I further understand that if the subscriber's health coverage is denied or terminated during the course of treatment, I am completely responsible for all payments of any services rendered. This includes co-payments and deductibles that are not reimbursed through the subscriber's insurance policy. I hereby authorize _____ to release all information necessary to secure the payment of benefits. I authorize the use of the signature below on all insurance submissions, whether manually or electronically.

*Patient (or guardian) signature: _____ Date: _____