New Patient Information

CLARKSTON PHYSICAL THERAPY

Patient Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

City: _____ Zip Code: _____ Emergency Phone: _____

Email: _____

Date of Birth: _____ Sex: ❑ Male ❑ Female SS# _____

Occupation: _____ Employer: _____

City: _____ State: _____ Zip: _____

Referring Physician: _____ Address: _____

City: _____ Zip Code: _____ Diagnosis Code: _____

INSURANCE INFORMATION

Primary: _____

Address: _____

Subscriber's Name: _____

Membership Number: _____

Group Number: _____

Secondary: _____

Address: _____

Subscriber's Name: _____

Membership Number: _____

Group Number: _____

❑ Job ❑ Auto ❑ Accidental

IF MARRIED

Spouse's Name: _____

Employed By: _____

Business Phone: _____

SS#: _____

Birth Date: _____

INFORMATION NEEDED FOR TREATMENT OF A MINOR

Mother's Name: _____

Address: _____

City/State/Zip: _____

SS#: _____

Employer: _____

Work Phone: _____

Father's Name: _____

Address: _____

City/State/Zip: _____

SS#: _____

Employer: _____

Work Phone: _____

EMERGENCY INFORMATION

Relative/Friend - Not living with you

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

I authorize Clarkston Physical Therapy to use and disclose health and medical information for the purposes of treatment, payment and Health Care Operations. Under all circumstances I assume final responsibiliry for my account. I consent to physical therapy services prescribed by any physician. I authorize payment of medical benefits by my insurance company to Clarkston Physical Therapy for Services Rendered. I have received this practice's Notice of Privacy Practices written in plain language.

Date: _____ Signature: _____

(PARENT OR GUARDIAN SIGNATURE REQUIRED IF PATIENT IS A MINOR)