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| **Therapeutic Dynamics**  Providing excellence in Orthopedic Manual Physical Therapy.  1810 Peachtree Industrial Boulevard • Suite 130 • Duluth, GA 30097• Ph: (770) 232-7100 • Fax: (770)232-7198 [theradyn@bellsouth.net](mailto:theradyn@bellsouth.net) |

NEW PATIENT INFORMATION SHEET

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| --- | --- | --- | --- |
| Account#: **D** | | | |
| **Referring Physician:** | | | | | | | | | **Primary Care Physician:** | | | | | | | | | | | | |
| **Next appointment with your referring Physician:** | | | | | | | | | | | | | | | | | | | | | |
| Diagnosis and ICD-9 codes: | | | | | | | | | Date of first appointment: | | | | | | | | Time: | | | | | |
| Patient First Name: | | | | | | Middle Name: | | | | | | | | Last Name: | | | | | | | | |
| DOB: | | SS#: | | | | | | | | | | | Sex :  M F | | | | | | Age: | | | |
| **e-mail address:** |  | | | | | | | | | | | | | | | | | | | | | |
| How did you hear about our clinic? | | | | | | | | | | | | | | Marital Status:  M  S  W  D | | | | | | | |
| Mailing Address: | | | | | City: | | | | | | | | | | | State:  **GA** | | | | Zip Code: | | |
| Home Phone:  **(****)** | | | | Cell Phone:  **(****)** | | | | | | | | | | | Work Phone:  **(****)** | | | | | | | |
| Employer Name: | | | | | | | | Work Address: | | | | | | | | | | | | | | |
| Emergency contact: | | | | | | | Relationship: | | | | | | | | Phone #:  **(****)** | | | | | | | |
| Parent/ Legal Guardian: | | | | | | | | | | Responsible Party:  **Self** | | | | | | | | | | | | |
| Is your condition related to an auto accident or a work related injury? | | | | | | | | | | Date symptoms began: \_\_\_\_\_\_\_\_\_\_\_  Date of injury:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | |
| **Have you had PT this year**?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Office use:** Medicare Cap Amount used: \_\_\_\_\_\_\_ | | | | | | | | | | **Office use:** Date Medicare cap checked:  By:  Does secondary cover after Medicare cap used? | | | | | | | | | | | | |
| Primary /Secondary Insurance Company : | | | | | | | | | | | | Insurance Phone # : | | | | | | | | |
| Patient Relationship : Self Spouse Child Other | | | | | | | | | | | | | | | | | | | | |
| Insured first Name: | | | | | Middle Name: | | | | | | Last Name: | | | | | | | | | | | |
| DOB of Insured: | | | SS# of insured: | | | | | | | | | | | | | | Sex  M F | | | | | |
| Policy/ID#: | | | | | | | | | | | | Group #: | | | | | | | | | | |