



ATLAS PHYSICAL THERAPY

NEW PATIENT INFORMATION

(Upper Section for Office Use Only)

Today's Date ____/____/____ Initial Evaluation Date ____/____/____ Time: _____

Last Name _____ First Name _____ MI _____

Referring Physician _____ Primary Care Physician _____ PCP Phone _____

Body part to be treated: _____

Birth Date ____/____/____ Age _____ Sex: M F (please circle) Marital Status: S M W D P (please circle)

Email Address _____ SS#: _____ - _____ - _____

Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ - _____ Work Phone (____) _____ - _____ Cell Phone (____) _____ - _____

Emergency Contact _____ Phone (____) _____ - _____ Hm Wk Cell Relationship _____

How did you learn about Atlas Physical Therapy? _____

Employer _____ Occupation _____ Employed: Full time Part Time

Employer's Address _____ City _____ State _____ Zip _____

Were you injured on the job? Y N Date of Injury ____/____/____ Claim No. _____

Name of Adjustor _____ Phone (____) _____ - _____

Were you injured in a car accident? Y N Date of Injury ____/____/____ Claim No. _____

Name of Attorney _____ Phone (____) _____ - _____

FOR MEDICARE RECIPIENTS ONLY:

Have you had or are you currently receiving home health? Y N Date of discharge: _____

Home health agency name: _____ Phone (____) _____ - _____

Primary Insurance

Complete blanks using *INSURED'S* information

Insured's Name _____

Sex: M F Birth Date ____/____/____ SS#: _____

Patient's relationship to insured _____

Employer _____

Employer's Address _____

City _____ State _____ Zip _____

Insurance Company _____

Phone (____) _____ - _____ - _____

Address _____

City _____ State _____ Zip _____

Insured's ID #: _____

Group #: _____

Secondary Insurance

Complete blanks using *INSURED'S* information

Insured's Name _____

Sex: M F Birth Date ____/____/____ SS#: _____

Patient's relationship to insured _____

Employer _____

Employer's Address _____

City _____ State _____ Zip _____

Insurance Company _____

Phone (____) _____ - _____ - _____

Address _____

City _____ State _____ Zip _____

Insured's ID #: _____

Group #: _____

Revised on 10/20/2007