ProCare Physical Therapy

New Patient Information

Today's Date: _____

How did you hear about us? Referral/By Whom? _____ Internet ___ Drive by ___ Other _____

Name: _____ Date of Birth: _____ SSN: _____

Street Address _____ **City/State/Zip Code:** _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

Employer Address/City/State/Zip Code:
_____

Emergency Contact/Relationship: _____ Daytime Phone #: _____

For the current year, have you received speech, occupational, pulmonary, or physical therapy prior to your visit today? No If yes, how many visits have you had? _____

Have you had any Chiropractic care this year? No If yes, how many visits? _____

Referring Physician: _____ Phone #: _____

Date and time of next scheduled follow-up appointment with Doctor? _____

Primary Care Physician: _____

Attorney's Name: _____ Phone # _____
(Complete **only if** Auto Accident or Workmen's Compensation Case)

Attorney's Address: _____

General Health Insurance Information:

Insured's Name (if other than self): _____

Insured's Date of Birth: _____ Insured's Employer: _____

Automobile Insurance Information (complete only if a car accident has occurred):

Insurance Company: _____

Policy #: _____ Phone#/Adjusters Name: _____

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