ProCare Physical Therapy

New Patient Information

Today's Date:_____

How did you hear about us? Referral/By Whom?_____ Phone Book_____ 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?_____ If yes, how many visits have you had?_____

Have you had any Chiropractic care this year?_____ 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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