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 _____ **Phone** _____ **Body part to be treated:** _____

Primary Care Physician _____ **Phone** _____ **Would you like reports forwarded to PCP?** ❑**Y** ❑**N**

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

Email Address _____

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	**Secondary Insurance**
Complete blanks using *INSURED'S* information	**Complete blanks using *INSURED'S* information**
Insured's Name _____	**Insured's Name** _____
Sex: M F Birth Date ____/____/____	**Sex: M F Birth Date** ____/____/____
Patient's relationship to insured _____	**Patient's relationship to insured** _____
Employer _____	**Employer** _____
Employer's Address _____	**Employer's Address** _____
City _____ **State** _____ **Zip** _____	**City** _____ **State** _____ **Zip** _____
Insurance Company _____	**Insurance Company** _____
Phone (_____)_____-_____	**Phone** (_____)_____-_____
Address _____	**Address** _____
City _____ **State** _____ **Zip** _____	**City** _____ **State** _____ **Zip** _____
Insured's ID #: _____	**Insured's ID #:** _____
Group #: _____	**Group #:** _____