Healing Integrations

New Patient Form

(PLEASE PRINT CLEARLY)

Name: _____

Soc. Sec. Number: _____ **Driver's Lic. Number:** _____ **Exp:** ____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **Email:** _____

Birth Date: _____ **Age:** _____ **Sex:** M / F **Are you under 18 years of age?** Yes / No

Emergency Contact: _____ **Phone Number:** _____

Referring Doctor: _____ **Phone Number:** _____

Primary Care Physician: _____ **Phone Number:** _____

Primary Insurance: _____ **Phone Number:** _____

ID Number: _____ **Group #:** _____

Secondary Insurance: _____ **Phone Number:** _____

ID Number: _____ **Group #:** _____

Was the injury work related? Yes / No

Area(s) receiving treatment: _____

_____

Whom may we thank for referring you? _____

CONSENT FOR TREATMENT OF A MINOR: As a parent and/or legal guardian, I authorize Healing Integrations to treat the minor named above while I am present, or while I am not present.

Parent/Legal Guardian Signature: _____ **Date:** _____

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize Healing Integrations Physical Therapy to furnish information to insurance carriers concerning this treatment.

Parent/Legal Guardian Signature: _____ **Date:** _____