

**New Patient Form** (can be filled out online and printed)

**Name:**

**Social Security Number:** **Driver’s License 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:**