



## NEW PATIENT INFORMATION SHEET

PATIENT NAME (Last, First, MI)		TELEPHONE 1	TELEPHONE 2	DATE OF BIRTH	
SOCIAL SECURITY #	STREET ADDRESS / PO BOX		TOWN	STATE	ZIP CODE
<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> OTHER		EMERGENCY CONTACT (Name / Phone)		EMAIL ADDRESS	
<b>PRIMARY INSURANCE AND GUARANTOR INFORMATION</b>					
INSURANCE COMPANY		DATE OF INJURY/ CONDITION		COPAY PER VISIT \$	
YOUR RELATIONSHIP TO POLICY HOLDER / GUARANTOR <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER		NAME OF POLICY HOLDER / GUARANTOR IF NOT PATIENT			
POLICY HOLDER or GUARANTOR'S DATE OF BIRTH		SS # OF THE POLICY HOLDER / GUARANTOR			
POLICY HOLDER or GUARANTOR'S EMPLOYER		GUARANTOR'S ADDRESS IF DIFF. THAN PATIENT			
<b>SECONDARY INSURANCE INFORMATION</b>					
I have 2 <sup>nd</sup> Ins. <input type="checkbox"/> I don't have 2 <sup>nd</sup> Ins <input type="checkbox"/>		2 <sup>nd</sup> INSURANCE COMPANY		COPAY PER VISIT \$	
YOUR RELATIONSHIP TO INSURANCE SUBSCRIBER: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER		NAME OF PERSON 2 <sup>nd</sup> INSURANCE POLICY IS UNDER:			
<b>PHYSICIAN INFORMATION</b>					
REFERRING PHYSICIAN		DATE LAST SEEN		NEXT APPOINTMENT DATE	
PRIMARY CARE PHYSICIAN		DATE LAST SEEN		NEXT APPOINTMENT DATE	
<b>IF WORKER'S COMP</b>					
COMPANY NAME		CASE MANAGER		CLAIM #	PHONE NUMBER
<b>IF THIRD PARTY PAYER</b>					
NAME		CONTACT PHONE		ADDRESS	

- Check here if you would like to receive a **reminder call** for appointments
- Check here if you would like to receive our monthly **e-newsletter** (you can easily unsubscribe at any time)
- Check here if you would like to receive your bill **electronically** (please provide e-mail address above)

*I hereby authorize the RehabGYM Inc. to release health care information necessary to file a claim with the above stated 3<sup>rd</sup> party payers and assign benefits payable to the RehabGYM Inc.*

\_\_\_\_\_  
Patient's (or Guardian's) *Signature*

\_\_\_\_\_  
Date