ALLIED PHYSICAL THERAPY & REHAB, INC.

NEW PATIENT INFORMATION

ACCOUNT # _____ **DATE** _____

☐ ***East Boston*** ☐ ***Framingham*** ☐ ***Foxboro*** ☐ ***Norwood***

Name _____ D.O.B. _____ Sex: ☐ *Male* ☐ *Female*

E-mail _____ Address _____

Town _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ SSN _____

Type of Case ☐ *Auto* ☐ *WC* ☐ *P.I. (S&F)* ☐ *Health* ☐ *Private* ***Date of Injury or 1st Treatment*** _____

Auto Insurance _____

Address _____ Town _____ State _____ Zip _____

Claim# _____ Adjuster _____ Phone _____

Med Pay ☐ Yes ☐ No Amount $ _____ Person Insured _____

Primary Health Insurance _____ Phone _____

Address _____ Town _____ State _____ Zip _____

Subscriber Name _____ ID# _____ Group _____

Co-pay Amount $ _____ Deductible Amount $ _____ Visits Allowed _____

Secondary Health Insurance _____ Phone _____ ID# _____

Work Comp Insurance _____

Address _____ Town _____ State _____ Zip _____

Claim# _____ Adjuster _____ Phone _____

U.R. Phone _____ U.R. Fax _____ Auth# _____

Attorney _____ Phone _____

Address _____ Town _____ State _____ Zip _____

Diagnosis Codes _____

Referring Doctor or PCP _____ Treating Doctor or P.T. _____

Who Referred Patient To Our Office _____

For Billing Department Only

Date Received ___/___/___ Date Entered ___/___/___