Alliance Physical Therapy
Because Experience Matters

NEW PATIENT INFORMATION

A New Patient Information Form Must Be Completed, If You Have Not Been Seen In 30 Days Or More

PATIENT INFORMATION				
First Name		MI	Last Name	
Street Address		City/State/Zip Code		
Contact Number	Type			
	Mobile	Email		
	Home	SSN		
	Work	DOB	Birth Sex (M/F)	

INSURANCE INFORMATION	
Primary Ins Co	Secondary Ins Co

***** Please Give Your Insurance Card(s) & ID Card (Driver's License) To The Front-Desk To Scan *****

INSURED INFORMATON					
Are You The Insured (Subscriber)	YES	NO	If **NO**, ***Complete*** the insured Information below If **YES**, your information is above, ***SKIP*** to guarantor section		
First Name			MI	Last Name	
Street Address			City/State/Zip Code		
Contact Phone Number		Type			
		Mobile	Email	Birth Sex (M/F)	
		Work	SSN	DOB	

WORK COMP INFORMATION				
W/Comp Ins Co	Injury Date	Claim #	Adjuster Name	Adjuster Phone
Employment Name	Employment Address		Employment Phone	

MOTOR VEHICLE ACCIDENT				
Accident Date	Policy Name	Claim Number	Contact Name & Number	Were You At Fault (Yes/No)

YOU MUST HAVE HEATLH INSURANCE IN ORDER FOR ALLIANCE PT TO TAKE YOUR MOTOR VEHICLE ACCIDENT INSURANCE OR YOU WILL BE SET UP AS A SELF-PAY PATIENT AT EACH VISIT. WE DO NOT TAKE ATTORNEY LIENS

EMERGENCY CONTACT			
Name	Date of Birth	Phone	Relationship

AGREEMENT	
By signing this form, I attest that all information on this form is accurate	
PRINT NAME	Relationship To Patient
SIGNATURE	DATE