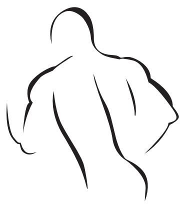

Alternative Back Care
PHYSICAL THERAPY *Achieving relief one back at a time*

New Patient Information Sheet

Directions: Print out New Patient Information Sheet, fill it out, and bring it with you to your first appointment or mail it to ABC Physical Therapy 3502 South 12th Street, Suite B, Tacoma, Washington

Date ___________ Referred by Doctor: ________________________ ☐Yellow Pages ☐ Friend ☐ Other: __________________

Patient Information

Name of Patient: ____ Marital Status: ☐S ☐M ☐D ☐W

Address: ____ How long? _______________

City: ____________________________________ State: ____________________ Zip: _________________

Home Telephone: ________________________________ Work Telephone: ____________________________________

Date Of Birth: __________________ Patient's Sex: ☐ M ☐ F Patient's Social Security # _______________________________

Employer: ____________________________ How Long? ___________ Occupation ___________________________________

If Married, Spouse's Name: ______________________________ Spouse's Social Security # ____________________________

Spouse's Employer: ___________________________ Occupation: __________________ Work Telephone: ________________

List any medications you are currently taking: ____

Primary Insurance / Secondary Insurance

Primary Insurance		Secondary Insurance	
Name of Insured:	Relationship to Patient:	Name of Insured:	Relationship to Patient:
Birth Date:	Employer:	Birth Date:	Employer:
Insurance Company/ Auto Carrier:		Insurance Company/ Auto Carrier:	
ID Number:	Group Number	ID Number:	Group Number
Insurance Claims Adjuster/ Phone Number		Insurance Claims Adjuster/ Phone Number	

Person To Call In Case Of Emergency

Name:	Address:	Phone:	Relationship

Although services may be covered by insurance, I understand I am fully responsible for payment for care I receive. I understand an administrative service charge of 1% compounded or $1.50 per month, whichever is greater, will be charged on all unpaid balances. I authorize payment of medical benefits to my physician for services rendered. I authorize the doctor or insurance to release any information required for services rendered by this office. I give ABC PT permission to use a collection service, if by chance my account is 90 days over do.

Signed: ____ Dated: ______________________