



REGISTERED PHYSICAL THERAPISTS, INC.
Advanced, Personalized Care To Get You Back To Work And Play Fast

NEW PATIENT INFORMATION

Today's date: _____

How did you hear about RPT?

Yellow pages White pages Mailer Insurance Doctor: _____ Friend: _____ Other: _____

Patients Name _____ Sex: M F S.S.# _____ - _____ - _____ Date of birth _____ - _____ - _____

Address _____ City _____ ST _____ Zip _____

Student status: FT PT NONE

H. Phone# _____ Marital status _____ Email address _____

Patients employer _____ W. Phone# _____ Can we contact you at work? _____

Employers address _____

Name, address and phone# of nearest relative: _____

SYMPTOM INFORMATION

Symptom first noticed _____ - _____ - _____ How did it occur _____

Work related? Y N Auto accident? Y N Date of accident _____ - _____ - _____

Did you need surgery? Y N Date of surgery _____ - _____ - _____

Last seen by doctor _____ - _____ - _____ Doctors name and Phone# _____

PRIMARY INSURANCE

Complete the spaces below with your primary health insurance unless your injury was due to an auto accident or is work related, if so the insurance of the vehicle you were in or your employers workers compensation information and your claim# is needed. In either of these cases enter your Primary **health** insurance under secondary insurance.

Policy holder _____ Sex: M F S.S.# _____ - _____ - _____ Date of birth _____ - _____ - _____

Address _____ City _____ ST _____ Zip _____

H. Phone# _____ W. Phone# _____ Employer _____

Insurance company _____ Phone# _____

Address _____ City _____ ST _____ Zip _____

ID# _____ Claim# _____ Group# _____ Relation to patient _____

SECONDARY INSURANCE

Policy holder _____ Sex: M F S.S.# _____ - _____ - _____ Date of birth _____ - _____ - _____

Address _____

H. Phone# _____ W. Phone# _____ Employer _____

Insurance company _____ Phone# _____

Address _____ City _____ ST _____ Zip _____

ID# _____ Claim# _____ Group# _____ Relation to patient _____