NEW PATIENT INFORMATION

Todays date:___________________

How did you hear about RPT?
□ Doctor: _________ □ Returning Patient □ Friend: ___________ □ Insurance □ Facebook □ Internet Search □ Other: ___________

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

Address ____City ____________________ST _______Zip ___________

H. Phone# ______________________ Cell Phone#________________________ Email address ________________________________

Patients employer __________________________________ W. Phone# ____________________ May we contact you at work? _________

Employers address ____

Name, address and phone# of nearest relative: ____

____ Marital status _______________________ _________

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 ________________________