

**New Patient Form**

**Corbin Physical Therapy**

**Patient Information Form**

Today's Date \_\_\_\_\_ Birthdate \_\_\_\_\_ Male or Female (circle one)  
Name \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
S.S. Number \_\_\_\_\_ Diagnosis/Problem \_\_\_\_\_  
Referring Doctor \_\_\_\_\_ Date Seen by Physician \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

***IN CASE OF EMERGENCY, PLEASE CONTACT***

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone/Cell \_\_\_\_\_

Fill Out Appropriate Section:

**A. Workers' Compensation Insurance Information (if work related)**

Name of Employer at time of injury \_\_\_\_\_ Date of injury \_\_\_\_\_  
Workers' Comp Insurance \_\_\_\_\_ Phone \_\_\_\_\_  
Claim Number \_\_\_\_\_ Adjuster \_\_\_\_\_

**B. Private Health Insurance Information (if billing your private health insurance)**

Primary Insurance Company \_\_\_\_\_  
Insurance Phone \_\_\_\_\_ Insured's Name \_\_\_\_\_  
Insured's ID# \_\_\_\_\_ Group Number \_\_\_\_\_  
Relationship to Insured \_\_\_\_\_

**C. Auto Insurance (if billing your auto insurance)**

Insurance Company \_\_\_\_\_ Insurance Phone \_\_\_\_\_  
Insured's Name \_\_\_\_\_ Date of Accident \_\_\_\_\_  
Adjustor's Name \_\_\_\_\_ Claim Number \_\_\_\_\_

**Assignment And Release**

I hereby authorize my insurance benefits to be paid directly to Southeastern Kentucky P.T., Inc. and I am financially responsible for non-covered services. I also authorize Southeastern Kentucky P.T., Inc. to release my information required to process this claim.

Patient Signature \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_