THERAPY PLUS HEALTH SOLUTIONS INC

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New Patient Form

Personal Information

First Name: _____

Last Name: _____

Date: _____/_____/_____ (MM/DD/YYYY)

DOB: _____/_____/_____ (MM/DD/YYYY)

Sex: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Contact Information

Phone Number: _____ ☐ Cell Phone ☐ Home Phone

Email: _____

Preferred Method of Communication: ☐ Cell Phone ☐ Email ☐ Other:

_____

Primary Care Physician

Name: _____

Emergency Contact

First Name: _____

Last Name: _____

Phone Number: _____ ☐ Cell Phone ☐ Home Phone

Email: _____

Relation to Patient: ☐ Spouse ☐ Sibling ☐ Parent ☐ Other: _____

Date:_____/_____/_____ Pt. Last Name:_____

Pt. First Name:_____

DOB: _____/_____/_____ (MM/DD/YYYY)

Insurance

Insurance Coverage: ☐ Blue Cross Blue Shield ☐ UnitedHealth Group ☐ Cigna

☐ Workers Compensation ☐ Medicare ☐ Auto Accident

☐ Out of Pocket/Cash

Primary Insurance ID: _____

Insurance Group: _____

Policy Holder Name: _____

DOB: _____/_____/_____ (MM/DD/YYYY)

Sex: _____

Relation to Patient: ☐ Spouse ☐ Sibling ☐ Parent ☐ Other: _____

Insurance Plan: ☐ HMO ☐ PPO