

**STOVER PHYSICAL THERAPY  
NEW PATIENT INFORMATION**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: Male or Female  
Employer Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Spouse's Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Family Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Referring Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance: \_\_\_\_\_ Member ID#: \_\_\_\_\_  
Insured Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ DOB: \_\_\_\_\_  
Secondary Insurance: \_\_\_\_\_ Member ID#: \_\_\_\_\_  
Insured Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ DOB: \_\_\_\_\_

**MEDICARE BENEFICIARIES ONLY:**

Are you currently receiving HOME-HEALTH CARE services, or have you received HOME-HEALTH CARE services in the last 30 days? Yes Or No  
If Yes, Name of Home Health Agency: \_\_\_\_\_ Phone #: \_\_\_\_\_

**FINANCIAL INFORMATION**

IF PATIENT IS MINOR: Name of Responsible Party: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

I understand and agree that I am ultimately responsible for the balances of any professional services rendered, regardless of my insurance. I certify that the information provided is true and correct to the best of my knowledge. I am also responsible for any changes in my status of the above information.

I understand that if I am unable to make regular payment on my account, I may be charged a 1.5% late fee, and agree to be responsible for any expenses incurred in collecting the balances on my account, including all fees (i.e., late fees, cancellation-no show fees) court costs, attorney's fees, and all other collection related expenses.

I give you and any of your agents, permission to call me on any phone number that I have provided to you, including all cell phone numbers, for collecting my debt.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, medical professional, and/or attorney involved in this case.

Patient or Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_