Lanier Therapy In Motion

New Patient Information Sheet

Please help us serve you better by taking a few minutes to provide the following information.

PATIENT INFORMATION

Last Name	First Name	MI	Nickname

Street Address	City	State	Zip

Home Phone	Work Phone	Cell Phone

Date of Birth	Sex	Marital Status	Social Security Number
		☐ Married ☐ Widowed ☐ Single ☐ Divorced ☐ Separated	

Employment	Referring Doctor	When is your follow up appointment with your referring doctor?
☐ Full ☐ Part ☐ Self ☐ Retired ☐ None ☐ Active Military ☐ Student		

SURGERY/ACCIDENT DETAILS – Please complete if visit is due to injury

Surgery? ☐ Yes ☐ No	Employment related? ☐ Yes ☐ No	Auto Accident? ☐ Yes ☐ No	Other Accident? ☐ Yes ☐ No	Are you receiving home health care at this time? ☐ Yes ☐ No
Date of Surgery:	Employer:	Date of Accident:	Date of Accident:	
	Date of Injury:	In which state:		

Please give details of accident/injury:

RESPONSIBLE PARTY/INSURED (If different from patient)

Last Name	First Name	MI	Date of Birth	Social Security Number

Relationship to Insured	Sex (M, F)	Employer:	Employer address and phone number:

EMERGENCY CONTACT INFORMATION

Relationship to Patient	Last Name	First Name

Home Number	Cell Number	Work Number

I authorize the release of any medical or other information necessary to process insurance claims.

Signed _____ Date _____

I authorize payment of medical benefits directly to this practice for services rendered.

Signed _____ Date _____