MTS PHYSICAL THERAPY & WELLNESS

NEW PATIENT FORM (Please Print Clearly)

First Name Last Name Middle Name

Mailing Address

City State ZIP

Street Address

City State ZIP

DOB SS# DL# Gender (circle) Male / Female

Home # Cell # Email

Patient's Status (circle) Married / Single / Divorced / Widowed / Other Student (circle) Full-time / Part-time

Employment Status (circle) Full-time / Part-time / Unemployed / Self-employed / Retired / Disabled

Place of Employment Occupation

Work # Address City State Zip

Spouse's Name DOB SS#

Spouse's Place of Employment Work #

RESPONSIBLE PARTY/GUARDIAN (if not the patient; or if patient is a minor (under the age of 18)

First Name Last Name Middle Name

Mailing Address

City State ZIP

Street Address

City State ZIP

DOB SS# DL# Gender (circle) Male / Female

Home # Cell # Email

Place of Employment Occupation

Work # Address City State Zip

Emergency Contact Contact's # Relationship

Are you currently a wellness member here at MTS Physical Therapy & Wellness? Yes / No

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NEW PATIENT FORM CONTINUED (Please Print Clearly)

PATIENT OR AUTHORIZED PERSON'S SIGNATURE

I authorize the release of any and all medical information necessary to process my claim for services provided by MTS Physical Therapy & Wellness, and request payment of benefits to MTS Physical Therapy & Wellness.

I hereby consent to the release & disclosure of my personal health information to MTS Physical Therapy & Wellness. This release authorization includes my personal health information consisting of MRI results, test results, etc. for the purpose of deciding a plan of treatment. I understand that MTS Physical Therapy & Wellness is permitted to send me unencrypted emails that pertains personal health information if advised by me and I am aware of the risk.

Patient's/Responsible Party's Signature **Date**