



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
Home Phone		Work Phone		Cell Phone		
Date of Birth	Sex	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated		Social Security Number		
Employment <input type="checkbox"/> Full <input type="checkbox"/> Part <input type="checkbox"/> Self <input type="checkbox"/> Retired <input type="checkbox"/> None <input type="checkbox"/> Active Military <input type="checkbox"/> Student		Referring Doctor		When is your follow up appointment with your referring doctor?		

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

Surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	Employment related? <input type="checkbox"/> Yes <input type="checkbox"/> No	Auto Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Other Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you receiving home health care at this time? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

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

Signed

Date

Signed

Date