



5950 Santo Road, Suite D, California 92124 • 858/715-3878 • Fax 858/715-3879

NEW PATIENT INFORMATION

PLEASE PRINT AND FILL IN **ALL** THE INFORMATION AND PROVIDE YOUR INSURANCE CARD AND DRIVER'S LICENSE FOR COPYING

Patient Name:		Sex:	Date of Birth:	Age:
Social Security Number:	Employment Status: Employed Unemployed Retired Student		Marital Status: Single Married Divorced	
Residential Address:				
Mailing Address:				
Home Phone:		Work Phone:	E-Mail Address:	
Employer:			Occupation:	
Employer's Address:				
Referring MD:	MD Address:		MD Phone:	
Attorney:	Attorney's Address:		Attorney's Phone:	
Financial Party: (if other than patient)	Relationship:	Social Security Number:	Date of Birth:	
Home Phone:	Work Phone:	Employer:		
Emergency Contact:		Relationship:	Home Phone:	
Address:			Work Phone:	
Insurance Company:		Insurance Phone:		
Name of Adjuster:	Claim Number:	Date of Injury:	Date of Surgery:	

In signing below, I agree to be treated by the staff of Adjust Therapy. I understand that I am financially responsible to Adjust Physical Therapy for all unpaid balances. I authorize the release of medical information necessary to process claims for services rendered by Adjust Physical Therapy. I authorize payment of medical benefits to Adjust Physical Therapy.

SIGNATURE _____ DATE _____