



# MI Therapy Clinic

25865 W 12 Mile Rd, Suite 104, Southfield, MI 48034  
(248) 208-7492 • Fax (248) 208-7494 • miclinics@gmail.com

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## NEW PATIENT INFORMATION

### Patient Information

<b>Patient Name (Last, First, M.I.)</b>		<b>Date</b>	
<input type="text"/>		<input type="text"/>	
<b>Date of Birth</b>	<b>Sex</b>	<b>Address</b>	
<input type="text"/>	Male      Female	<input type="text"/>	
<b>Parent / Guardian (if minor)</b>	<b>Home Phone</b>	<b>Work / Cell Phone</b>	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
<b>Social Security #</b>	<b>Email</b>		
<input type="text"/>	<input type="text"/>		
<b>Emergency Contact</b>	<b>Emergency Phone</b>	<b>Relationship</b>	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
<b>Referring Physician</b>	<b>Physician Phone</b>	<b>Physician Fax</b>	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

### Injury Information

<b>Date of Injury / Onset</b>	<b>Body Region(s) Affected</b>	<b>Side Affected</b>		
<input type="text"/>	<input type="text"/>	Right	Left	Both

### Primary Insurance

<b>Primary Insurance</b>	<b>Contract / ID #</b>		
<input type="text"/>	<input type="text"/>		
<b>Subscriber Name</b>	<b>Subscriber DOB</b>	<b>Group #</b>	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
<b>Insurance Provider Contact #</b>			
<input type="text"/>			



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## NEW PATIENT INFORMATION — CONTINUED

### Secondary Insurance

Secondary Insurance

Contract / ID #

Subscriber Name

Subscriber DOB

Group #

Insurance Provider Contact #

### Coverage Questions

If Medicare, is the patient currently receiving Home Health services?	Yes	No
Has the patient had Physical, Occupational, or Speech Therapy this year?	Yes	No
Is the injury / condition an auto-related accident?	Yes	No
Is this injury / condition a work-related accident?	Yes	No

### Auto / Workers' Compensation Only

State of Accident

Open Claim?

Yes      No

Claim #

Insurance Company

Address

Insurance Contact #

Case Manager Phone

Case Adjuster Phone

### Patient Authorization

I certify the information above is accurate to the best of my knowledge.

Patient Signature

Date

### Therapist Use Only

Therapist Signature

Date