



Date \_\_\_\_\_

**Patient:** \_\_\_\_\_  Male  Female Age \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last Name First Name Middle Initial

**Responsible party (if a minor) & relationship to patient:** \_\_\_\_\_

**Street Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Please list 2 methods of contact for you: Phone #1** \_\_\_\_\_ **Phone #2** \_\_\_\_\_  
Home Work Cell Home Work Cell

**E-mail address** \_\_\_\_\_ \* We collect e-mail addresses for Inspirit Therapy Assoc. use only.

Would you like email appointment reminders?  Yes  No Would you like to receive our newsletter by email?  Yes  No

**Reason for Visit** \_\_\_\_\_

Was your injury due to a motor vehicle accident?  Yes  No Was your injury due to a work injury?  Yes  No

**Referring Provider** \_\_\_\_\_

**Emergency Contact** \_\_\_\_\_ **Relationship to you:** \_\_\_\_\_

**Phone** \_\_\_\_\_ **Alternate Phone** \_\_\_\_\_

**Patient Employment Information**

**Employed**  Full-time  Part-time  Retired  Unemployed **Student**  Full-time  Part-time

**Occupation** \_\_\_\_\_ **Business Phone** \_\_\_\_\_ ext. \_\_\_\_\_

**Employer** \_\_\_\_\_

**Business Address** \_\_\_\_\_

**Billing Information**

Do you have Insurance?  Yes  No If yes, please complete the following:

Name of **Primary** Insurance Company \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Insured ID \_\_\_\_\_ Insured Group Number \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Insured's Employer Name \_\_\_\_\_

Name of **Secondary** Insurance Company \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Insured ID \_\_\_\_\_ Insured Group Number \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's DOB \_\_\_\_/\_\_\_\_/\_\_\_\_