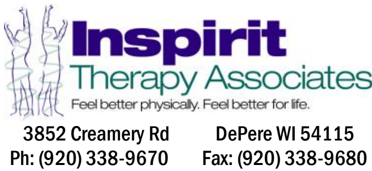

3852 Creamery Rd DePere WI 54115
Ph: (920) 338-9670 Fax: (920) 338-9680

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 _____________________ Home Work Cell **Phone #2** _________________ 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 __ _____/_______/________

Insured's Employer Name____