



Coddington Physical Therapy
1550 South Coddington Avenue, Suite C Lincoln, NE 68522

New Patient Information Form

Patient Information:

Name: _____ Date of Birth: _____ Age: _____
Nickname: _____ Email Address (optional): _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
SS#: _____ Gender: M or F Marital Status: Single Married Widowed Divorced
Employer: _____ Occupation: _____
Who referred you to our office? _____
Reason for visit: _____ Onset of current condition: _____
Do you reside in a long term care or skilled nursing facility? Y or N

Insurance Information:

Primary Insurance Company: _____
Primary Insured Name: _____ Primary Insured Date of Birth: _____
Relationship to patient: _____
Primary Insurance ID #: _____ Primary Insurance Group #: _____
Secondary Insurance Company: _____
Primary Insured Name: _____ Primary Insured Date of Birth: _____
Relationship to patient: _____
Secondary Insurance ID #: _____ Secondary Insurance Group #: _____
If someone other than the patient being seen is responsible, please list responsible party below:
Responsible Party Name: _____ Responsible Party Date of Birth: _____
Relationship to patient: _____
Address: _____ City: _____ State: _____ Zip: _____

In case of Emergency:

Who would you like us to contact in case of emergency?
Name: _____ Phone Number: _____ Relationship to patient: _____

Worker's Compensation or Auto Accident Information:

Were you injured at your job? If so, please complete the following information.

Employer Name: _____ Contact Person: _____ Phone Number: _____
How were you injured: _____ Date of injury: _____
Worker's Comp insurance company name: _____ Claim #: _____

Were you involved in an auto accident? If so, please complete the following information.

Auto Insurance Company: _____

Contact Person: _____ Phone Number: _____

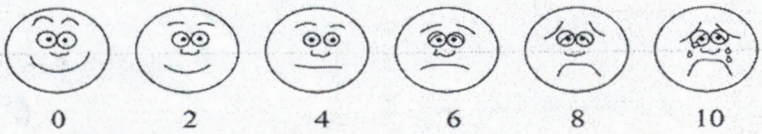
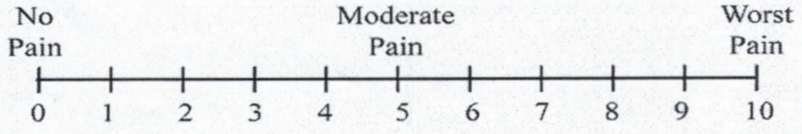
Claim #: _____ Date of accident: _____

Are you currently working with an attorney? If so, please list below:

Name of Attorney: _____ Phone Number: _____

PQRS Information:

1. Pain Status: Where is your pain located? _____



2. History of Falls:

Number of falls in the past 12 months: _____

Injuries from falls (please specify): _____

3. Please list all medications you are currently taking: _____ (copy provided to office)

Current known medical conditions:

Previous Surgeries and approximate date of surgery:

Consent for Treatment/ Assignment of Benefits/ Release of Information

I understand that I have been referred to Coddington Physical Therapy, Inc. and authorize Coddington Physical Therapy, Inc. to provide rehabilitation services as per my referral and/or developed, modified, and progressed at the direction of Coddington Physical Therapy, Inc. clinicians and/or my physician. I also assign directly to Coddington Physical Therapy, Inc. ass medical benefits payable to my insurance company, Medicaid, or Medicare benefits. I authorized release of any records necessary to secure payment of benefits to my insurance company, Medicaid, or Medicare.

Medicare patients only: Certification and Financial Agreement- I certify that the information given by me is applying for payment under TITLE XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration (Medicare) and its agents any information needed for this or a related Medicare claim. I request that the payment for authorized benefits be made directly to Coddington Physical Therapy on my behalf. I understand that I am responsible for any medical insurance deductible and co-insurance, and for the cost of the difference of any private accommodation in which I am placed at my own request.

Patient Name: _____ Date: _____

Patient Signature: _____

CPT Office Use Only

Diagnosis: _____