

# Patient Information

Patient Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Birth Date: \_\_\_\_\_ SS#: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Mobile Phone: (\_\_\_\_\_) \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Employment Related \_\_\_\_\_ Automobile Related \_\_\_\_\_

Have you received any therapy within the last calendar year? \_\_\_\_\_

Marital Status: Single Married Divorced Patient Sex: M F

Employment Status: Employed F/T Student Retired Occupation: \_\_\_\_\_

Bill to Information: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer Contact Phone: (\_\_\_\_\_) \_\_\_\_\_ Contact Name: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

I HEREBY CERTIFY THAT ALL INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE, AND I AM RESPONSIBLE FOR ALL CHARGES INCURRED FOR THESE SERVICES. LATE PAMENTS MAY BE SUBJECT TO 1.5% FINANCE CHARGES. I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIM AND AUTHORIZE MY INSURANCE COMPANY TO PAY *new beginning therapeutic services llc* DIRECTLY FOR SERVICES RENDERED.

IF YOU MUST BRING SOMEONE WITH YOU TO THERAPY, WE REQUEST THAT THEY REMAIN IN THE WAITING ROOM.

PATIENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(AUTHORIZED REPRESENTATIVE IF PATIENT UNABLE TO SIGN)



**new beginning therapeutic services llc.**

office: 706-253-NBTS (6287) • mobile: 706-692-8095 • fax: 706-253-6289  
email: kbaker@nbts.us • 371 Noah Drive. • Suite 102 • Jasper, Georgia 30143