

**McDonald Physical Therapy**

**Medicare New Patient Questionnaire**

Patient name \_\_\_\_\_

First Middle Last Name Preferred

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_ SSN# \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_ Home Phone (\_\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_

E-mail Address \_\_\_\_\_ Drivers License # \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Employer Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone \_\_\_\_\_

Responsible Party (self, if over 18 years old) \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

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

Name and Relationship

Would you be interested in speaking with a social worker? Yes \_\_\_ or No \_\_\_

**Medicare patients only:** Have you recently received any services from a Home Health Care Agency? \_\_\_\_\_

Date of last home health care visit \_\_\_\_\_ Discharge date \_\_\_\_\_

**Who is to be billed: Private Insurance \_\_\_\_\_ Work Comp \_\_\_\_\_ Auto/Accident Insurance \_\_\_\_\_ Self \_\_\_\_\_**

**Primary SSN \_\_\_\_\_ Primary DOB \_\_\_\_\_**

**Primary card holder's name and relationship to patient \_\_\_\_\_**

**Permanent Home Address (if different) \_\_\_\_\_**

**City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone \_\_\_\_\_**

**Secondary SSN \_\_\_\_\_ Secondary DOB \_\_\_\_\_**

**Secondary card holder's name and relationship to patient \_\_\_\_\_**

**Permanent Home Address (if different) \_\_\_\_\_**

**City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone \_\_\_\_\_**

Referring Doctor \_\_\_\_\_ Area of Injury \_\_\_\_\_ Approximate Injury Date \_\_\_\_\_

Please list the health care professionals that you would like us to send progress reports to and sign your name in the space provided.

\_\_\_\_\_ Signature \_\_\_\_\_

**CONSENT TO PHYSICAL THERAPY  
(Please read before you sign)**

- 1. I authorize the staff of McDonald Physical Therapy to carry out all procedures as ordered by my physician on the referral form.
- 2. I authorize the release of any medical information necessary to process this claim.
- 3. I authorize payment directly to McDonald Physical Therapy for physical therapy services rendered. I understand that I am financially responsible for charges not covered by third party payers. (For Medicare and Private Insurances).

\_\_\_\_\_  
SIGNATURE OF PATIENT (if the patient is a minor parent must sign) Date \_\_\_/\_\_\_/\_\_\_

**PLEASE DO NOT REMIND ME OF MY APPOINTMENTS**