Michigan Therapeutic Solutions, Inc

New Patient Information

Patient Name:_____ Date: _____
Last First M.I.

DOB:_____ ☐ Male ☐ Female

Address: _____
City State Zip Code

Parent / Guardian (if patient is a minor): _____

Patient Home Phone #:_____ Work/Cell #: _____

Social Security #: _____

Emergency Contact:_____ Phone #: _____

Relationship to patient: _____

Referring Physician Name: _____

Physician Phone #:_____ Physician Fax #: _____

Injury Information

Date of Injury / Condition:_____ Side Affected: ☐ Right ☐ Left ☐ Both

Body Region Affected: _____

Insurance Information

Primary Insurance:_____ Contract/ID #: _____

Subscriber Name:_____ Subscriber DOB: _____

Group #:_____ Insurance Provider Contact #: _____

Secondary Insurance:_____ Contract/ID#: _____

Subscriber Name:_____ Subscriber DOB: _____

Group #:_____ Insurance Provider Contact #: _____

If Medicare, is the patient currently receiving Home Health Care Services? (nursing, therapy, home health aide) ☐ Yes ☐ No

Has the patient had Physical, Occupational or Speech Therapy this year? ☐ Yes ☐ No

Is this injury/condition an auto related accident? ☐ Yes ☐ No
If yes, please fill out the Auto/Workman's Comp section on page 2

Is this injury/condition a work related accident? ☐ Yes ☐ No
If yes, please fill out the Auto/Workman's Comp section on page 2

Auto / Workmans Compensation Patients Only

What State was the accident in?_____ Is this an Open Claim? ____

Claim #:_____ Insurance Company: _____

Address:_____ Ins. Contact #: _____

_____

Subscriber Name:_____ Subscriber DOB: ____

Case Manager Name:_____ Contact #:_____ Fax #: ____

Case Adjuster Name:_____ Contact #:_____ Fax #: _

Is the case currently under legal proceedings? _____

I certify that all of the information provided is correct

Patient Signature:_____ Date: _____