

PATIENT INTAKE FORM

PLEASE FILL OUT COMPLETELY AND CLEARLY

Date: _____ **Patient's Legal Name:** _____

Nickname: _____ **[] Male [] Female** **DOB:** _____ **SSN:** _____

Mailing Address: _____ **City/State/Zip:** _____

Main Phone: _____ **Cell:** _____ **Email Address:** _____

Primary Insurance: _____ **Secondary Insurance:** _____

Primary Insured Name: _____ **Relationship to patient:** _____

Primary Insured DOB: _____ **Primary Insured SSN:** _____

Primary Insured Mailing Address (if different from the above):

WORK
COMP
&
MVA

Date of Injury: _____	Claim #: _____
Insurance Company: _____	Phone #: _____
Address: _____	State: _____ Zip: _____
Adjuster/Case Manager: _____	
Is an attorney involved? [] Yes [] No - Attorney Name/Phone#: _____	

Employer: _____ **Occupation:** _____

Address: _____ **Phone#:** _____

Medicaid Patients: *Who is your Passport Provider:* _____ *Date of last visit:* _____

Have you had any of these therapies in the *past year*? [] PT [] OT [] Speech [] Chiropractic [] Cardiac/Pulmonary **or** [] No
If yes, when was it? _____ How many? _____ Was it at our clinic [] Yes [] No Was it for the *same injury*? [] Yes [] No

Referring Physician: _____ **Phone:** _____

Emergency Contact: _____ **Phone:** _____ **Relationship:** _____

Please sign below to acknowledge that the above information is accurate, that you have received the **HIPAA Notice of Privacy Practices** handout, and to authorize our clinic to treat for physical therapy.

Signature of Patient: _____ **Date:** _____

Information below is required for treatment of a minor or a patient who does not have their own power of attorney.

Name of Parent or Legal Guardian: _____ **Signature:** _____

[] I would like to receive appointment reminders via email.