

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):

W
O
R
K

C
O
M
P

&

M
V
A

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 therapy in the **past 12 months**? [] 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.