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 <u>any</u> of these therapies in the *past year*? [ ] PT [ ] OT [ ] Speech [ ] Chiropractic [ ] Cardiac/Pulmonary **<u>or</u>** [ ] 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.

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