PHYSICAL THERAPY INTAKE FORM

MR# _____

APT. DATE _____

Ratient Information (Confidential)

Name _____ Home Phone _____

Social Security # _____ Male ☐ Female ☐ Birthdate _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Patient Employer _____ Work Phone _____

Person to contact in case of emergency _____ Phone # _____

Injury Information

Referring Physician _____ Phone # _____

Date of Injury _____ Surgery date _____ Diagnosis _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to patient _____

Address _____ Home Phone _____

Birthdate _____ SS# _____ Cell Phone _____

Co-pay is due in full at each appointment.

Insurance Information

Primary Insurance Company _____ ID# _____ Group # _____

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# _____ Name of Employer _____

How much is your deductible? _____ Do you have a copay? ☐ Yes ☐ No Amount? _____

DO YOU HAVE ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Secondary Insurance Company _____ ID# _____ Group # _____

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# _____ Name of Employer _____

How much is your deductible? _____ Do you have a co-pay? ☐ Yes ☐ No Amount? _____

Medicare Patients

PLEASE INFORM US IF YOU ARE CURRENTLY ALSO RECEIVING HOME HEALTH CARE. YOU WILL BE LIABLE FOR PHYSICAL THERAPY SERVICES IF THIS OCCURS. _____ INITIALS

Work or Auto Related

Name of Insurance Company _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Fax # _____ Claim # _____

Adjuster's Name _____ Phone # _____ Fax # _____

Nurse Case Manager _____ Phone # _____ Fax # _____

How would you like to be reminded of your appointments?

We do text messaging, voice call or E-mail reminders

Please check **ONE**.

Text Messaging	Phone number:	
Voice Call	Phone number:	
E-mail	E-mail address:	

Have you had any other Physical Therapy treatment **THIS YEAR??**

please check **ONE**

Yes?	No?