

## PATIENT INTAKE FORM

### Demographic Information

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Date: \_\_\_\_\_

Patient's Legal Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Male  Female

Street Address: \_\_\_\_\_ PO Box: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

SSN: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Person Responsible for Unpaid Balances: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ PO Box: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

### Insurance Information

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Primary Insurance: \_\_\_\_\_

Claims Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Policy Holder SSN: \_\_\_\_\_ Policy Holder DOB: \_\_\_\_\_

Policy Holder Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Claims Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Policy Holder SSN: \_\_\_\_\_ Policy Holder DOB: \_\_\_\_\_

Policy Holder Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

## Injury Information

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Date of Injury:

Date of Surgery:

Is injury result of an accident? YES NO AUTO WORK SCHOOL Other:

Is there a lawsuit pertaining to this injury? YES NO

If yes, Lawyer Name:

Address:

PO Box:

City:

State:

Zip:

Phone:

Referring Physician:

Clinic Name:

City:

Phone:

Have you had physical therapy, for this or any other condition, during this calendar year? YES NO

If YES, where?

How many visits?