

# 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: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ Phone#: \_\_\_\_\_

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#: _____	

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 If no, where? \_\_\_\_\_  
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.**