Confidential Patient Intake Information

Name ____ Date of Birth ________ /________ /______________

Address ____ SS# (optional) _______ - _______ - ______________

City _____________________________ State ______ Zip ____________ (H) Phone ___________________________________

Single ____ Married ____ Other ____ (C) Phone ___________________________________

Parent/guardian (***if patient under 18)***______________________________ (W) Phone ___________________________Ext______

Address ____ Preferred contact phone is (H)______(C) ______(W)_____

City ______________________________ State _______ Zip __________ **Do you want appointment reminder calls?** ________

May we leave voice messages at the phone numbers provided? __________

May we leave messages with anyone who answers the phone numbers provided? __________

Email ____ **Do you want appointment reminder e-mails**? ________

Please note: Electronic communication is non-encrypted and at-risk. By signing this form you accept this risk and give authorization to contact you as indicated above.

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Spouse/Partner/Significant Other ____________________________________ (H) Phone ________________________________

Address ____ (C) Phone _________________________________

City __________________________________ State _______ Zip ___________ (W) Phone ________________________Ext _____

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Emergency Contact _____________________________________ Relationship _____________________ Phone ______________________

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Employer ____

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Have you had physical therapy in the last 12 months? ____ If yes, explain ____

Why are you being seen today? ____ Auto Accident? _____ Work Comp?_____

If accident or w/comp give DOI __________ Claim # ________________ Adjuster Name _____________________ Phone _____________

Referring Physician ____Primary Care Physician _____________________________________

If no card to copy: Primary Insurance Company __________________________________ Policy # _________________________________

Secondary Insurance ____ Policy # _________________________________

Name of Primary Insurance Cardholder (if not patient) ____

I hereby authorize the release of medical information necessary for processing insurance claims and payment of medical benefits for myself or the party who accepts assignment of benefits:

Signed ____ *Date* _______________________________________