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)*:

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#:_____

Have you had any therapy in the ***past 12 months***? [ ] PT [ ] OT [ ] Speech [ ] Chiropractic [ ] Cardiac/Pulmonary **or** [ ] 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.