Patient Intake Form



Patient Information	
Email Address: New Patient Paperwork Emailed: Case #:	
Patient:Today's Da	te:Reminder Call Demail Phone Text None
Name of Caller & Relation (if other than patient)	
Previous Patient: Yes No How did patient hear about us?	
Name of Referral (if applicable)	
Address	Apt/Unit # City State Zip
DOB Cell Phone	Alt. Phone
Diagnosis/Reason for Therapy	
SX DatePhysician Name	
Date on Script Freq/Duration _	F/U/MD Appt
Referred to a specific clinician \square Yes \square No \square Clinician Name \square	
Auto Accident 🗆 Yes 🗆 No 🔝 If yes, what state did accident occur in	
Was patient injured on the job \square Yes \square No \square If yes, what state is employer located in \square	
Primary Insurance	Secondary Insurance
Name of Insurance	Name of Insurance
Type of Insurance PPO POS EPO HMO	Type of Insurance \square PPO \square POS \square EPO \square HMO
Policy Holder Name	Policy Holder Name
Policy Holder DOB	Policy Holder DOB
ID Number	ID Number
Group/Policy #	Group/Policy #
Insurance Phone #	Insurance Phone #
Auto Accident - If this is an auto accident, notify FOC immediately	
Is patient represented by an attorney \square Yes \square No Attorney Name Phone #	
Does patient have a claim under their own auto insurance \square Yes \square No Claim #	
Always ask patient for their health insurance information \square Provided \square Denied	
Is patient claim third party or other liable party responsible \square Yes \square No Name $_$	
Workman's Comp/Auto/Liability	
Date of InjuryC	Claim #
Claim Adjuster's Name	Phone #
Nurse Case Manager's Name	Phone & Fax #
NCM EmailN	ICM Contact Preference 🗌 Phone 🗌 Email
Attorney Name	Phone #
Employer Name	Phone #
Insurance Company Name	Phone #
Day & Date of Eval Time	
Clinician Call Taken By	
CIV Use Only	

Date_

VOB Verified By_