Patient Intake Form

FRANKLIN REHABILITATION
Where personalized care gets proven results.

Patient Information

Email Address: _____ New Patient Paperwork Emailed: ☐ Case #: _____

Patient: _____ Today's Date: _____ Reminder Call ☐ Email ☐ 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 Date _____ Physician Name _____

Date on Script _____ Freq/Duration _____ F/U/MD Appt _____

Referred to a specific clinician ☐ Yes ☐ No Clinician Name _____

Auto Accident ☐ Yes ☐ No If yes, what state did accident occur in _____ Police Report ☐ Yes ☐ No

Was patient injured on the job ☐ Yes ☐ No If yes, what state is employer located in _____

Primary Insurance

Name of Insurance _____

Type of Insurance ☐ PPO ☐ POS ☐ EPO ☐ HMO

Policy Holder Name _____

Policy Holder DOB _____

ID Number _____

Group/Policy # _____

Insurance Phone # _____

Secondary Insurance

Name of Insurance _____

Type of Insurance ☐ PPO ☐ POS ☐ EPO ☐ HMO

Policy Holder Name _____

Policy Holder DOB _____

ID Number _____

Group/Policy # _____

Insurance Phone # _____

Auto Accident - If this is an auto accident, notify FOC immediately

Is patient represented by an attorney ☐ Yes ☐ No Attorney Name _____ Phone # _____

Does patient have a claim under their own auto insurance ☐ Yes ☐ No Claim # _____

Always ask patient for their health insurance information ☐ Provided ☐ Denied

Is patient claim third party or other liable party responsible ☐ Yes ☐ No Name _____

Workman's Comp/Auto/Liability

Date of Injury _____ Claim # _____

Claim Adjuster's Name _____ Phone # _____

Nurse Case Manager's Name _____ Phone & Fax # _____

NCM Email _____ NCM 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

VOB Verified By _____ Date _____