# Patient Intake Form

## 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 _____

Enrolled in Home Health? ☐ Yes ☐ No If yes, Name of Agency/Staff Member _____ Ph _____ Date of DC ____

Have you had physical therapy anywhere else this calendar year? ☐ Yes ☐ No If yes, Where? How many visits?

## 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 # _____

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 _____