## Patient Intake Form



Patient Information	
Email Address:Ne	w Patient Paperwork Emailed:  Case #:
Patient:Today's Da	te:Reminder Call $\square$ Email $\square$ Phone $\square$ Text $\square$ 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 Police Report 🗆 Yes 🗆 No	
Was patient injured on the job 🗆 Yes 🗆 No 🔝 If yes, what state is employer located in	
Primary Insurance	Secondary Insurance
Name of Insurance	Name of Insurance
Type of Insurance PPO POS EPO HMO	Type of Insurance PPO POS EPO 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 🗆 Yes 🗆 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 $\square$ 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