Confidential Patient Intake Information

Name ____ Date of Birth _______ /_______ /_______

Address ____ SS# (optional) ______ - ______ - ____________

City _____________________________ State ______ Zip ____________ (H) Phone _______________________________

Single ____ Married ____ Other ____ (C) Phone _______________________________

Parent/guardian if patient under 18 _______________________________ (W) Phone ________________________Ext_____

Address ____ Preferred contact phone is: ___(H) ___(C) ___(W)

City ______________________________ State _______ Zip __________ E-mail ___________________________________

How did you hear out about AC Physical Therapy? ____

Spouse ____ (H) Phone ________________________________

Address ____ (C) Phone ________________________________

City ______________________________ State _______ Zip __________ (W) Phone ________________________Ext _____

Employer ____ Phone ____________________________________

Address ____ City ___________________________ State ________Zip_________

Emergency Contact ____ Relationship _______________________________

Address ____ Phone ____________________________________

City _______________________________ State ________ Zip ___________

Have you had physical therapy in the last 12 months? ____ If yes, explain ____

Why are you being seen today? ____ Auto Accident? ____ Work Comp?____

If accident or w/comp give DOI __________ Claim # _____________ Adjuster Name __________________ Phone _____________

Referring Physician _____________________________________Primary Care Physician ____________________________________

<u>If no card to copy</u>: Primary Insurance Company __________________________________ Policy # ___________________________

Secondary Insurance ____ Policy # ___________________________

Primary Insurance Cardholder (if not patient) ____

I hereby authorize the release of medical information necessary for processing insurance claims and payment of medical benefits for myself or the party who accepts assignment of benefits:

Signed ____ *Date* ____________________________________