Patient Information Form

Date of Call/Registration: Past Patient: □ Yes □ No		**Patient Account Number**:	
Patient Information			verified DL/photo ID: □ Yes □ No
Last Name/Suffix	First Name	Middle Initial:	
Address:	City:	State:	Zip Code:
Home Phone: Contact Method: □Ph □Em □ Mob □Txt	Mobile Phone: Text Enabled □	Email Address: No Appointment Reminders □	
Date of Birth:	SSN:	Sex: □M □F	Status: □Single □Married □Divorced □Widowed □Separated □Unknown
Employer Information			
Employer Name:		Employment Status: □ None □FT □PT □Self-Emp. □Retired □Student	
Address:	City:	State:	Zip Code:
Work Phone Number:	Patient Occupation:		
Emergency Contact Information			
Contact Name:	Phone:	Relationship to Patient: □Parent □Spouse □Sibling □Other	
Physician Information			
Name of Referring Physician:	Phone:	RX Date: Eval/Treat: □ # of Visits:	

Additional Questions				
Date of Injury Onset Date	Auto Related: □Yes-State? □No Adjuster Name _____ Phone # _____	Work Related: □Yes □No	Accident Related: □Yes □No	Diagnosis/Body Part
Post-Surgical: □ Yes / □ No / □ Unknown Surgery Date (if applicable):		Surgery Description: _____ _____		
Have you any prior Therapy this year? □ Yes □ No (PT/OT/SP or Chiropractic)		How did you hear about us?		

MEDICARE ONLY – Additional Questions

If Medicare, are you currently receiving Home Health Service? □ Yes □ No If yes, Name of Agency?_____
If Yes, what type of Home Health Services are you receiving?_____ Last Date of Service _____
Are you currently residing in a Skilled Nursing Facility? □ Yes □ No If Yes, Name of Facility? _____
If Yes, are you on/in the "Medicare Unit"? □ Yes □ No

If Medicare, have you received PT, OT or Speech services since the first of the year? □ Yes □ No

- If Yes, do you know if you have exceeded your Medicare Therapy Cap Amount? □ Yes □ No
- Are you Aware of any partial amount used since the first of the year? $ _____
- If Yes, please bring in any billing information from your previous therapy, or contact your previous provider for the information. Please bring the Medicare benefit summary you receive from Medicare.

Appointment Date:	Time:	Therapist:
Intake Completed By:_____Date _____	Patient, Please initial here if the above information is complete and correct _____ Date: _____	