# PATIENT INTAKE

***FOR OFFICE USE ONLY***

**RX Date:** _____/_____/_____ **# of visits prescribed:** _________ **Therapist Name:** _______________

**Referring MD:**_________________________ **Phone:**____________________**Fax:**_______________________

**PATIENT'S INFORMATION**: **Social Security #:** ____________________ **ACCT #:** _________

**Patient's Name: Last:**______________________________ **First:**___________________________

**Address:** ___________________________________________________________________

**Primary Ph:** ( ) __________________ **Secondary Ph:** ( ) _________________ **DOB**__________

**Marital Status:** Married / Single / Divorced / Widowed/ Other **Sex:** M / F

**Emergency Contact:** Name: ________________________________ Phone: ______________________

**INSURED'S INFORMATION:** Patient's relation to Insured: **Self / Spouse / Child / Other**

**Insured's Name:** ________________________________________________ **DOB:** _________

**Address:** ___________________________________________________________________

**Home Ph: ( )** _________ **Work Ph:** ( ) _________ **DOB:** _________

**ACCIDENT INFORMATION:** Accident Type: **None / Auto / Work** **Date of Accident**: _______________

**Surgery?** Y / N **Surgery Date:** ______ **Reason for visit:**________________________________________

**Description of accident:** _________________________________________________________

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**PRIMARY INSURANCE:** ______________________________________________________________

**Phone:** ( ) __________________ **Fax:** ( ) _______________________

**I.D. Number:** _______________________________________ **Group Number:** _________________

**Insurance Rep.**_____________________________________ **Massage Covered?**________________________

**Effective Date**: ______ **Deductible:** _________ **Met:** ___________ **OOP:**________ **Met:**_______

**Co-pay:** _________ **Max visit limit or $ amount:** ___________ **Pre Cert. Required:** Y/ N

**Per visit billable unit max? Y / N Units:** ______________

**Benefits:**____________________________________________________________________________

______________________________________________________________________________________

**SECONDARY INSURANCE:** ________________________________________________________________

**Phone:** ( ) __________________ **Fax:** ( ) _______________________________

**I.D. Number:** ________________________________ **Group Number:** ______________________

**Insurance Rep:** _________________________________________________ **DOB:** ________

**Effective Date:**____________ **Deductible:**____________ **Met:**_______ **Copay:** _________ **OOP:** _____

**Per visit billable unit max? Y / N Units:** ______________

**Benefits:**_____________________________________________ **Max visit limit or $ amount**: __________

**Will you process as primary when current primary has been exhausted?** ___________________________

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to First Choice Physical Therapy. I understand that I am financially responsible for any balance. I also authorize First Choice Physical Therapy or insurance company to release any information required to process my claim.

______________________________ Date: ______________

Patient Signature