Sandy Physical Therapy - Patient Intake Form

PATIENT INFORMATION

First Name:	Last Name:	Middle Initial:	Date: / /

Address:	City:	State:	Zip:

Birth date: / /	Age:	☐ Male ☐ Female	S.S. #:

Home Ph: ( )	Cell Ph: ( )	Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other

E-mail Address:

Chose Clinic Because: ☐ Dr. ☐ Insurance ☐ Family/Friend ☐ Former Patient ☐ Website ☐ Internet Yellow Pages

☐ Yellow Pages ☐ Other _____ Whom may we thank for your referral:_____

WORK INFORMATION

Employer:	Work Ph: ( )	Ext.

Occupation:	Employment: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed

CARE PROVIDER INFORMATION

Referring Dr.:	Referring Dr.'s Ph.:
Regular Dr./PCP:	Regular Dr./PCP's Ph.:

IN CASE OF EMERGENCY

Name of Local Friend or Relative (Not Living at Same Address):

Relationship to Patient:	Home Ph: ( )	Work Ph: ( )

INSURANCE INFORMATION (PLEASE HAND YOUR INSURANCE CARD TO THE RECEPTIONIST)

Primary Insurance Name:

Subscriber's Name (If different):	Subscriber's Birth date: / /

I.D. #:	Grp #:	Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Oth:

Secondary Insurance Name:

Subscriber's Name:	Subscriber's Birth date: / /

I.D. #:	Grp #:	Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Oth:

AUTO OR WORK INJURY CLAIM (PLEASE PROVIDE YOUR PRIVATE HEALTH INSUR. INFO. FOR BACKUP)

Insurance Name: ☐ Auto: ☐ Workers Comp (please choose one)

Address:	City	State:	Zip:	Ph: ( )

Name of insured:	Employer at time of Injury:	Ph: ( )

Claim #:	Adjuster's name:	Accident Date: / /

ATTORNEY INFORMATION (IF APPLICABLE)

Name:	Law Firm:	Ph: ( )

Address:	City:	State:	Zip:

I authorize my insurance company to make payment directly to Nancy P. Monnie, P.C. for services rendered, and the release of therapy records if necessary to process my claim. I have given consent and permission for the attending therapist to treat me (or my minor child if applicable), and understand that I will be responsible for payment of physical therapy services.

PATIENT/GUARDIAN SIGNATURE

DATE

Please Print Name

Relationship to patient