

Sandy Physical Therapy Patient Intake Form

PATIENT INFORMATION					
First Name:	Last Name:	Middle Initial:	Date: / /		
Address:		City:	State:	Zip:	
Birth date: / /	Age:	<input type="checkbox"/> Male <input type="checkbox"/> Female	S.S. #:		
Home Phone: ()	Alternative Phone (Cell, Pager): ()		Spouse:		
E-mail Address:					
Chose Clinic Because: <input type="checkbox"/> Dr. <input type="checkbox"/> Insurance <input type="checkbox"/> Family/Friend <input type="checkbox"/> Former Patient <input type="checkbox"/> Website <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other					
Whom may we thank for your referral:					
WORK INFORMATION					
Employer:			Work Phone: ()	Ext.	
Occupation:	Employment status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Not Employed				
CARE PROVIDER INFORMATION					
Referring Dr:			Referring Dr. Phone: ()		
Primary Care MD:			Primary Care MD Phone: ()		
IN CASE OF EMERGENCY					
Name of Local Friend or Relative (Not Living at Same Address):					
Relationship to Patient:		Home Phone: ()	Work Phone: ()		
INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)					
Primary Insurance Name:					
Subscriber's Name (If different):			Subscriber's Birth date: / /		
I.D. #:		Group/Policy #:			
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:					
Secondary Insurance Name:					
Subscriber's Name:			Subscriber's Birth date: / /		
I.D. #:		Group/Policy #:			
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:					
AUTO OR WORK INJURY CLAIM (PLEASE ALSO PROVIDE ABOVE YOUR PRIVATE HEALTH INSUR. INFO.)					
Insurance Name: <input type="checkbox"/> Auto: <input type="checkbox"/> Workers Comp (please choose one)					
Address:		City	State:	Zip:	Phone: ():
Name of insured:		Employer at time of Injury:		Phone: ()	
Claim #:		Adjuster's name:		Accident Date: / /	
ATTORNEY INFORMATION					
Name:		Law Firm:		Phone: ()	
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