Orthopedic and Sports Physical Therapy Patient Intake Form

Date_____ Birth Date_____ Social Security Number_____
Patient Name_____ Employer_____
Address_____ Business Phone_____
City/State/Zip Code_____ Occupation_____
Phone #_____ Marital Status_____
E-Mail_____ Driver's License #/State_____
Emergency Contact/Relationship_____ Phone #_____

Primary Insurance_____ Secondary Insurance_____
Policy Holder_____ Policy Holder_____
ID Number_____ ID Number_____
Do you have any other insurance policies_____
Are you currently a full time student? YES___ NO___ School_____

Is this injury the result of an accident? ___Auto ___Work ___School ___Other_____
Date of Accident_____ State where accident occurred_____
Is this accident in litigation? YES___ NO___
Will you be submitting any of your medical bills to the accident insurance? YES___ NO___
Insurance Company_____ Claim #_____
Adjustor's Name_____ Adjustor's Phone #_____
Address_____

Referring Physician_____ Phone Number_____
Primary Care Physician_____ Phone Number_____
Date of Injury_____ Have you had surgery? YES___ NO___ N/A___ Surgery Date _____
Have you had Physical Therapy this calendar year? YES___ NO___ How many visits?____
How did you hear about Sports Physical Therapy? Friend Family Doctor Other_____
Are you presently under the care of an Athletic Trainer? YES___ NO___
If yes, school/ ATC name_____

I certify the above information is correct to the best of my knowledge. I understand that I am financially responsible for all charges whether or not covered by insurance. I also understand that if charges are allowed but not covered by my insurance company, I will be responsible for payment in full of any of these charges, as well as any co-payments, deductibles and/or supply purchases. I authorize treatment by the physical therapist at Orthopedic and Sports Physical Therapy.

Initial_____ Date_____

****Optional****

I authorize Orthopedic and Sports Physical Therapy to charge my Visa or MasterCard for any charges incurred during my treatment. These charges may include, but are not limited to, co-pays, co-insurance, deductible or supplies.

Credit Card Number_____ Exp. Date_____

Signature_____ Date_____