

## Patient Information

Last Name/Suffix		First Name		Middle Initial
Address:		City	State:	Zip Code:
Home Phone		Other Phone (Cell)		Email Address:
Date of Birth	SSN	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Unknown	

## Employer Information

Employer Name:		Employment Status: <input type="checkbox"/> None <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Self-Emp. <input type="checkbox"/> Retired <input type="checkbox"/> Student		
Work Phone Number		Patient Occupation		

## Primary Insurance Carrier / Policy Holder Information

Primary Insurance:		Insurance Identification Number:		
Policy Holder Name:		Is policy holder a <b>RETIRED</b> Federal Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to Patient: <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Other
Policy Holder Date of Birth:	Policy Holder SSN		Policy Holder Address:	
Policy Holder Home Phone:		Employer / Employer Address:		

## Secondary Insurance Carrier / Policy Holder Information

Secondary Insurance:		Insurance Identification Number:		
Policy Holder Name:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to Patient: <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Other	
Policy Holder Date of Birth:	Policy Holder SSN		Policy Holder Address:	
Policy Holder Home Phone:		Employer / Employer Address:		

## Physician Information

Name of Referring Physician:	Name of Primary Care Physician:
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## Emergency Contact Information

Contact Name:	Phone #:	Relationship to Patient: <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Sibling <input type="checkbox"/> Other	
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## Additional Questions

Date of Injury / Onset Date	Accident Related: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Auto-State? _____ <input type="checkbox"/> PI	Work Related: <input type="checkbox"/> Yes <input type="checkbox"/> No	Diagnosis/Body Part
Post Surgical: <input type="checkbox"/> Yes / <input type="checkbox"/> No / <input type="checkbox"/> Unknown Surgery Date (if applicable): _____		Surgery Description: _____	
Have you had any prior Therapy this year? <input type="checkbox"/> Yes <input type="checkbox"/> No (PT/OT/SP or Chiropractic)		How did you hear about us?	

***I understand that if any changes are made to my personal or insurance information while being treated it is my responsibility to inform the facility of said changes in a timely manner***

Appointment Date:	Time:	Therapist:
Intake Completed By: _____ Date: _____		I, acknowledge that the above information is correct <b>Patient/Guardian</b> _____ <b>Date:</b> _____