INTERNET FORM

Patient Information Form

Patient Demographic Information				
Last Name	***First Name***	***Middle Initial***		
Address	Apt/Bldg/Ste#	City	State	Zip Code
Home Phone	***Appointment Reminder Contact Method*** (Choose method of choice)	☐Text ☐Mobile ☐Email ☐Home Phone ☐No Appointment Reminder		
Mobile Phone	***Email Address***	☐Declined Email ☐No Email		
Date of Birth	SSN	***Sex*** ☐F ☐M	Status ☐Single ☐Married ☐Other	

Employer Information			
Employer	Employment Status ☐ FT ☐PT ☐None ☐Retired ☐Student		
Address	City	State	Zip Code
Work Phone	Occupation		

Emergency Contact Information		
Contact Name	Phone	Relationship

Physician Information		
Referring Physician	Phone	Script Date

Additional Questions			
Injury /Onset Date	Post-Surgical ☐Yes ☐No	Surgery Date	Body Part/DX
Work Related ☐Yes ☐No	Accident Related ☐Yes ☐No	Auto Related ☐Yes ☐No	Attorney Involved ☐Yes ☐No
Adjuster/Nurse Cases Mgr.	Phone	Attorney	Phone
Have you had prior Therapy this year? (PT/OT/SP/Chiro) ☐Yes ☐No	How did you hear about us?		

Medicare ONLY! Additional Questions	
If Medicare, are you currently Receiving Home Health Services? ☐Yes ☐No	
If YES, Name of Agency:	If discharged what is last date of service?
Are you currently residing in a Skilled Nursing Facility? If Yes, Name of facility	

Primary Insurance Section		Secondary Insurance Section	
Insurance/Plan		***Insurance/Plan***	
Policy ID #		***Policy ID #***	
Group #		***Group #***	
Insurance Phone		***Insurance Phone***	
Are you the policy holder? ☐Yes ☐No If no, continue		Are you the policy holder? ☐Yes ☐No If no, continue	
Card Holder Name	DOB	Card Holder Name	DOB
Patient Relationship to Policy holder ☐Self ☐Spouse ☐Child		Patient Relationship to Policy holder ☐Self ☐Spouse ☐Child	
Patient, Please initial here if the above information is correct and complete			Date

Office Staff use ONLY (below)		
Intake Completed by	Date	***Date Eval Scheduled***
Registered by	Date	Acct #
Patient Service Specialist will initial next to each task below once completed.		
Billing Disclosure added in RT Comments☐	Verified DL/Photo ID☐	Consent to receive calls and/or text messages, reviewed with patient. If patient agrees and signed consent, is text enabled box checked in RT?☐

Last updated 8/24/18