



Choose How You Age

PATIENT INTAKE FORM

Initial Evaluation is Scheduled For: _____ @ _____ with _____

PATIENT INFORMATION -To be filled out by patient

First name:		Last name:		M.I.:
Address:		City:	State:	Zip:
DOB: / /	Age:	Male <input type="checkbox"/> Female <input type="checkbox"/>	SS#: - -	
Home phone #:	Cell phone #:		Email:	
Employer:		Occupation:		

EMERGENCY CONTACT - To be filled out by patient

Name:	Relationship to patient:
Home phone #:	Alternate #:

PROVIDER CARE INFORMATION - To be filled out by patient

Referring physician:	Referring physician phone #:
Body part injured:	Surgery: Yes <input type="checkbox"/> No <input type="checkbox"/> Date: / /

INSURANCE INFORMATION -To be filled out by patient

Name primary insurance:		Insurance phone #:
Subscribers name:		DOB: / /
ID #:	Group policy #:	
Patient relation to insured: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		
Name of secondary insurance:		
Subscribers name:		DOB: / /
ID#:	Group #:	Relation: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/>

AUTO OR WORK INJURY CLAIMS ONLY -To be filled out by patient, as needed

Auto insurance name:	Worker's comp. carrier:		
Adjuster/Claims manager:	Phone #:	Ext:	
Address:	City:	State:	Zip:
Claim#:	Accident date: / /		

INSURANCE VERIFICATION -To be filled out by the Active Rx staff

In network deductible:	Deductible remaining:	Co-Pay/Co-Insurance :
Out network deductible:	Deductible remaining:	Co-Pay/Co-Insurance :
Payment agreement:		
Authorized visits remaining:	Benefits explained to patient: Yes <input type="checkbox"/> No <input type="checkbox"/>	

I authorize my insurance benefits to be paid directly to Active Rx Physical Therapy. I understand that I am financially responsible for any balance.

Signature: _____ Date: _____

Relationship to Patient: _____