



IE DATE: _____

PT NAME: _____

CLAIM # _____

Patient # _____

Patient Information (Complete This Section Only)

▶ Last Name _____	First Name _____	▶ Date of Birth (DOB) _____	Gender: M/F _____
▶ Address _____		Social Security Number (SS#) _____	
City _____	State _____	Zip _____	Primary Care Physician (PCP) _____
▶ Home Phone _____	Cell Phone _____	Referring Physician _____	
Email _____	Employer _____	Work Phone _____	
Emergency Contact Name & Phone _____		▶ Reason for Physical Therapy _____	

Primary Insurance (Office Use Only)

▶ Insurance: _____	Plan Name: _____
▶ MVA or WC? Yes or No (circle one); If yes, complete 2nd page of Patient Intake Form	
▶ ID# _____	Group# _____ Effective Date _____
Guarantor's Name: _____	Relationship to patient: _____
Deductible Ind. \$ _____ Met \$ _____	OOP Max Ind. \$ _____ Met \$ _____
Fam. \$ _____ Met \$ _____	Fam. \$ _____ Met \$ _____
Co-Pay \$ _____ Patient pays _____ %	Insurance pays _____ % _____
# visits authorized _____	visits used YTD _____ PCP Referral/Scrip? _____
Contact Person _____ # _____	Date _____ Caller's Initials _____

Secondary Insurance (Office Use Only)

▶ Insurance: _____	Plan Name: _____
▶ ID# _____	Group# _____ Effective Date _____
Contact Person _____ # _____	Notes: _____

Reviewed with patient on _____ By _____

I understand that the information above is NOT a guarantee of benefits and I know that the guarantor, as the insurance holder, is ultimately responsible to know benefits.

Patient Signature: _____ Date: _____