PATIENT INTAKE FORM

RESPONSE PHYSICAL THERAPY

PATIENT INFORMATION

Today's Date:

First Name: | Last Name: | Middle Initial: | SS#:

☐ Male ☐ Female | Date of Birth MM/DD/YYYY | Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address: Street Address | City | State | Zip Code

Email Address: | How would you like to receive appointment reminders? ☐ Text ☐ Email

Phone: ☐ Cell ☐ Home ☐ Work | Alternate Phone: ☐ Cell ☐ Home ☐ Work

Emergency Contact: | Phone: | Relationship to Patient:

Response Physical Therapy is permitted to discuss medical records of the patient with this contact? ☐ Yes ☐ No

WORK INFORMATION

Employer: | Work Phone:

Occupation: | Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Not Employed

PHYSICIAN INFORMATION

Referring Physician: | Date of Injury:

Referring Physician Phone: | Referring Physician Practice:

Regular Physician/PCP: | Regular Physician/PCP Phone:

INSURANCE INFORMATION (Provide Insurance card to receptionist)

Primary Insurance Name:

Subscriber's Name: | Date of Birth:

Phone #: | SS #:

Relationship to Patient: ☐ Self ☐ Spouse/Domestic Partner ☐ Parent ☐ Other

Subscriber #: | Group/Policy #:

Subscriber's Employer: | Phone:

***Do you have secondary coverage? ☐ Yes ☐ No

Secondary Insurance Name:

Subscriber's Name: | Date of Birth:

Phone #: | SS #:

Relationship to Patient: ☐ Self ☐ Spouse/Domestic Partner ☐ Parent ☐ Other

Subscriber #: | Group/Policy #:

Subscriber's Employer: | Phone:

Referral:

Chose clinic because: ☐ Doctor ☐ Insurance ☐ Family/Friend ☐ Former Patient ☐ Internet ☐ Other

Whom may we thank for your referral?