

Patient Name: Last \_\_\_\_\_ First: \_\_\_\_\_ MI \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Social Security # \_\_\_\_\_ Employer/Occupation: \_\_\_\_\_

Home PH: ( ) \_\_\_\_\_ Work PH: ( ) \_\_\_\_\_ Cell PH: ( ) \_\_\_\_\_

Birth date: \_\_\_/\_\_\_/\_\_\_ Sex Male or Female Marital Status: M S D W U Injury site/Diagnosis: \_\_\_\_\_

E-Mail Address (if you would like Dee PT updates) \_\_\_\_\_

**Are you currently receiving service from the VNA or Home Health?** YES NO

**Insurance Information**

Primary Insurance Name: \_\_\_\_\_ Policy/Claim # : \_\_\_\_\_

Group # : \_\_\_\_\_

Secondary Insurance Name: \_\_\_\_\_ Policy/Claim # : \_\_\_\_\_

Group # : \_\_\_\_\_

**Insurance Policy Holder**

Relation to Patient: Self: \_\_\_\_\_ Spouse: \_\_\_\_\_ Parent: \_\_\_\_\_ Other: \_\_\_\_\_

Last: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Home PH: ( ) \_\_\_\_\_ Work PH: ( ) \_\_\_\_\_

Social Security #: \_\_\_\_\_ Sex M or F Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

**Accident Information**

Have you had surgery for this injury: **Y or N** Accident type: None Workers Comp. Auto

Accident/Injury/Onset Date: \_\_\_/\_\_\_/\_\_\_ Accident Details: \_\_\_\_\_

Have you received physical therapy, occupational therapy, or chiropractic services since January of this year? **YES NO**

Do you have an attorney for this injury? YES NO Attorney Name/Address: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Is this a sports related injury? YES NO If so, which school or team? \_\_\_\_\_

**Patient/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**\*\*\*Office use Only\*\*\***

Referring Physician: \_\_\_\_\_ Office: \_\_\_\_\_ UPIN # \_\_\_\_\_

Admit Date \_\_\_/\_\_\_/\_\_\_ Re-eval date \_\_\_/\_\_\_/\_\_\_ Referral Date: \_\_\_/\_\_\_/\_\_\_ Cxl list (Y/N) \_\_\_\_\_ Entered \_\_\_\_\_

Therapist Name \_\_\_\_\_

Services Authorized by: \_\_\_\_\_ Adjusters Name: \_\_\_\_\_

Adjusters PH: \_\_\_\_\_ Fax: \_\_\_\_\_

Policy Effective date: \_\_\_/\_\_\_/\_\_\_ Deductible: \_\_\_\_\_ Amount of deductible met: \_\_\_\_\_

Out of pocket: \_\_\_\_\_ Amt of OOP met: \_\_\_\_\_ Patient%: \_\_\_\_\_ Co-pay: \_\_\_\_\_ Primary care ref (Y/N) \_\_\_\_\_

Max visits allowed: \_\_\_\_\_ Visits already used: \_\_\_\_\_ Max amount allowed: \_\_\_\_\_ Amount already used: \_\_\_\_\_

Benefits exhausted (Y/N) \_\_\_\_\_ Pre-Cert required (Y/N) \_\_\_\_\_ Pre-Cert Telephone # \_\_\_\_\_

Patient Account # \_\_\_\_\_ Verified by: \_\_\_\_\_