



Patient Intake Sheet

Patient Name: Last: _____ First: _____ MI: _____

Address: _____ City: _____ State/Zip: _____

Home PH: () _____ Work PH: () _____ Cell PH: () _____

Birth Date: ___/___/___ Sex: Male or Female E- Mail Address _____ private __ work __

Injury site/Diagnosis: _____

Insurance Information

___ Indemnity ___ Worker's Comp. ___ Auto

Primary Ins Name: _____ Policy/Claim#: _____ Group#: _____

Secondary Ins Name: _____ Policy/Claim#: _____ Group#: _____

Received PT, OT, ST or chiropractic services since 1/1/10? YES NO **If yes, how many visits? ___

Receiving service from the VNA or Home Health? YES NO

Insurance Policy Holder

Relation to Patient: Self: ___ Spouse: ___ Parent: ___ Other: _____ Sex: M or F

Last: _____ First: _____ MI: _____ Birth Date: ___/___/___

Address: _____ City: _____ State/Zip: _____

Home PH: () _____ Work PH: () _____

Employer Name: _____ Address: _____

Person Financially Responsible - Relation to Patient: Self: ___ Spouse: ___ Parent: ___ Other: _____

Last: _____ First: _____ MI: _____ Birth Date: ___/___/___

Address: _____ City: _____ State/Zip: _____

Home PH: () _____ Work PH: () _____

Verification

___ Referral Log ___ Entered

Referring Physician: _____ PCP: _____

Referral Date: ___/___/___ Admit Date: ___/___/___ Therapist Name: _____

Primary Insurance Authorized By: _____ Policy Effective Date: ___/___/___ Benefits Exhausted(Y/N): ___

Deductible: _____ Amount of Deductible Met: _____ OOP Limit: _____ Amt of OOP met: _____

Patient%: _____ Co-Pay: _____ Max Visits Allow: _____ Visits Used: _____ Referral(Y/N): ___

Max Amt allowed: _____ Amt Already Used: _____ Pre-cert Required (Y/N): ___ Per-Cert PH: _____

Secondary Insurance Authorized by: _____ Special Instructions: _____

Orthotics Device (Y/N): _____ Special Instructions: _____

Patient Account #: _____ Verified By: _____ Date: _____

I have reviewed the above information and attest that it is correct: _____