

INITIALS: _____

PATIENT INTAKE FORM

DATE SCHEDULED: _____

Prev. Acct. #: _____

NEW ACCOUNT# _____

TIME: _____ THERAPIST: _____

3.20.06-KJE

Time here for ppwk: _____

PATIENT NAME _____ **DATE OF BIRTH** _____ MALE ___ FEMALE ___

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

HOME NUMBER _____ **WORK NUMBER** _____ Email: _____

DIAGNOSIS/PROBLEM _____ **ONSET DATE OF INJURY** _____

OCCUPATION _____ EMPLOYER _____ SSN: _____

MARITAL STATUS (Please Circle One): S M D O Will you need child care? . YES . NO

EMERGENCY CONTACT NAME _____ PHONE # _____

HOW DID YOU HEAR ABOUT DUNN PHYSICAL THERAPY? _____

PHYSICIAN INFORMATION: Referring MD Practice name: _____

REFERRING PHYSICIAN _____ PHONE # _____

PRIMARY CARE PHYSICIAN _____ PHONE # _____

PRIMARY INSURANCE _____ **SUBSCRIBER NAME** _____

RELATIONSHIP TO PATIENT _____ ID # _____ GROUP # _____

ADDRESS _____ PHONE # _____

SUBSCRIBER'S BIRTH DATE _____ SUBSCRIBER'S EMPLOYER _____

SECONDARY INSURANCE _____ **SUBSCRIBER NAME** _____

RELATIONSHIP TO PATIENT _____ ID # _____ GROUP # _____

ADDRESS _____ PHONE # _____

SUBSCRIBER'S BIRTH DATE _____ SUBSCRIBER'S EMPLOYER _____

WERE YOU IN AN AUTO ACCIDENT? . YES . NO **Date of Accident:** _____ **Auto Ins Name:** _____

CLAIM # _____ Claims Adjustor Name: _____ PHONE# _____ FAX# _____

ADDRESS: _____ OPTIONS: Medpay Primary Ins. Auto Ins w/ 20% pymt

ATTORNEY NAME _____ PHONE # _____ Practice: _____

WERE YOU HURT AT WORK? . YES . NO **Injury Date:** _____ **CLAIM #** _____

Employer Name: _____ **Employer Address:** _____

Employer Phone: _____ **HR Mgr Name:** _____ **HR Mgr Phone #** _____

Workers Comp Ins Name: _____ **W/C Ins Billing Address:** _____

W/C Ins. Phone # _____ CASE MGR NAME _____ PHONE# _____

Patient SSN _____ Patient notified that RX Needed? . YES . NO

IS THIS A PERSONAL INJURY CASE INVOLVING AN ATTORNEY? . YES . NO

ATTORNEY NAME _____ PHONE # _____ Practice: _____

For Office Use Only:

Verified by: _____ **Date:** _____

DEDUCTIBLE _____ HOW MUCH HAS BEEN MET? _____ OOP: _____

% INSURANCE COVERS? _____ PATIENT'S COINSURANCE? _____ COPAYMENT? _____

IS THERE A MAX # OF RX VISITS PER YEAR? YES NO HOW MANY? _____ Combined w/ OT, CHIRO? Y N

DO WE NEED TO SEND RX FROM REFERRING DOCTOR? _____ LETTER OF MEDICAL NECESSITY? _____

DO WE NEED PREAUTH FROM REFERRING DOCTOR? _____ ELECTRONIC PAYOR ID# ? _____

ADDRESS TO SEND BILLS: _____

DATE VERIFIED _____ CONTACT PERSON _____