Patient Intake Questionnaire

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code:_____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ SSN: _____

Email Address: _____

***By providing your e-mail address, you expressly consent to receive e-mails from us. We do not provide or sell your address 3rd party.**

Marital Status: S M D W Sex: M F Former Patient: Yes No

How did you hear about us? _____

Patient Employer: _____

Occupation: _____ Full Time/Part Time: _____

Employer Address: _____ Ph: # _____

Emergency Contact Name/Phone #: _____

Relationship to Patient: _____

Referring Physician: _____ Phone: _____

Address: _____

If you are a Medicare patient, have you been involved in a home health episode? Yes No

Is this treatment due to injuries sustained in an accident? Yes No

If related to accident, what type of accident? ☐ Employment ☐ Motor Vehicle ☐ Personal Injury

☐ Other: _____ City/State of Accident: _____

Is this treatment covered by any other payer than your personal insurance? Yes No

If yes, who? _____

Are you represented by an attorney? Yes No

If yes, Attorney name: _____ Attorney Phone: _____

Patient Intake Questionnaire

Auto/3rd Party Information

Were you or another party at fault? _____ Date of Accident _____

Name and address of other party_____

Patient Auto Insurance Company _____ Claim # _____

Claims Mailing Address: _____

Insured's Name: _____

Other party Auto Insurance Company _____ Claim # _____

Claims Mailing Address: _____

Insured's Name: _____

Has the accident been reported? Yes No Is there a police report? Yes No

Workers Compensation

Employer's Name: _____ Employer Ph: _____

City/State where injury occurred? _____

Insurance Company: _____ Claim #: _____

Adjuster Name: _____ Phone #: _____

Address: _____ Fax #: _____

Case Manger Name: _____ Phone #: _____

Address: _____ __ Fax #: _____

Are you currently working full duty? Yes No

Private Insurance

Primary Insurance Company: _____

Name of Policy Holder? _____ Date of Birth _____

Relationship to Patient _____

Policy Holder Employer: _____

ID # _____ Group #: _____

Secondary Insurance Company: _____

Name of Policy Holder? _____ Date of Birth _____

Relationship to Patient _____

Policy Holder Employer: _____

ID # _____ Group #: _____