PATIENT DATA SHEET

Account #: __________

Appointment Date: ____/____/______ Intake completed by: ________________Date: __________

Appt Time: _____ am/pm

PATIENT INFORMATION

Social Security #: __________________________________ Birthdate: ____/____/_________ Sex: ☐M ☐ F

Name: (Last) __________________ (First) _______________ (MI) _____ Suffix/Nickname: ________________

Address: ____ Home Phone: (_______) _______ - ___________

City: _____________________ State: _____ Zip: ________ Work Phone: (_______) ________ - __________

Employer: ____ Cell Phone: (_______) ________ - _________

Employer Address: _________________________________ City/State/Zip: ___________________________________

Occupation: ______________________________________ Marital Status: ☐ M ☐ S ☐ W ☐ D ☐ U

How did you hear about our facility? ____

Email: ____

Emergency Contact: __________________________________ **Contact Phone: (_______) _______ - _________**

Relation to Patient: ___________________________________

May we leave personal information on the phone number above? ☐ Yes ☐ No _____________________

FOR OFFICE USE ONLY *Therapist: ____*

Referring Physician or Profile #: _________________________ NPI: ________________ License#: ___________

Physician Phone: ( ) _______________ Physician Fax: ( ) ____________________

Physician Address: _________________________________ City/State/Zip: ________________________________

Diagnosis Code: ____________________ Services Ordered: ☐PT ☐OT Body Part(s): ____________________

Prescription Date: ____/____/____ # Visits Ordered: _________ Specific Orders: ____________________

RESPONSIBLE PARTY INFORMATION

Social Security #: __________________________ Relation to Patient: Self Spouse Parent Other

Insured's Name: ____________________________ Birthdate: ____/____/_______ Sex: ☐ M ☐ F

Address: ____ Home Phone: (______) ________ - _________

City/State/Zip: ___________________________________ Work Phone: (______) ________ - _________

Employer: ____ Cell Phone: (______) ________ - _________

Employer Address: _________________________________ City/State/Zip: ________________________________

ACCIDENT / INJURY / ONSET – INFORMATION

Previous surgery **for this body part**? ☐ Yes ☐ No Acc/Injury/Onset Date: ____/____/__________

Date of surgery: ______/______/_______ (exact date of injury for auto or work)

Accident type: (circle) Work /Auto / Other (accident due to other than auto or work) / None (not an accident)

Accident details: ____

If accident, please include where and how accident happened; if non-accident, include reason for visit.)

If accident, State where accident occurred? ________ Check if accident was "NO FAULT" ☐ (no potential liable party)

PAYOR INFORMATION Verification Phone: (______) _______ – ________

Payor Name: ____ Claim Phone: (______) _______ - _______ ext ________

Policy/Claim #: _____________________ Group#: _________________ Group/Adj. Name: __________________

2ndary Ins? ☐ Yes ☐ No _______________________________ ID#:_________________________________ GR#____________________

Card Holder Name: _________________________ DOB :_____/_____/______Verification Phone:____________________

FOR OFFICE USE ONLY

Patient Signature: (all information on this form is correct): _________________________________**Date:**_________