



# Physical Therapy Works

## PATIENT INTAKE

Date: \_\_\_\_\_ Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Social Security# \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex \_\_\_\_\_

Street/Box: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Doctor Ordering Therapy: \_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Other \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Was this due to a Motor Vehicle Accident: Yes \_\_\_\_\_ No \_\_\_\_\_ Worker's Comp Claim? Yes \_\_\_\_\_ No \_\_\_\_\_

Diagnosis/Chief Complaint: \_\_\_\_\_ Right \_\_\_\_\_ Left \_\_\_\_\_

### Primary Insurance Policy Holder

Person Responsible: \_\_\_\_\_ Their DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Their Employer: \_\_\_\_\_ Their Social Security# \_\_\_\_\_

### Secondary Insurance Policy Holder

Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer: \_\_\_\_\_ Their Social Security# \_\_\_\_\_

I have been informed and offered a copy of the Notice of Privacy Practices. By initialing this I acknowledge that I have been offered a copy of the Notice of Privacy Practices \_\_\_\_\_ (Initials)

This Authorization is effective for 1 year after the date it is signed. I understand that I may revoke this authorization at any time for any further or additional releases by contacting Physical Therapy Works.

\_\_\_\_\_  
Signature of Patient or Authorized Person

\_\_\_\_\_  
Date

\_\_\_\_\_  
If the Patient is a Minor, the Responsible Parent or Guardian Signature

\_\_\_\_\_  
Parent or Guardian SSN#

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Patient Photo Taken Yes No if no why \_\_\_\_\_

Photo ID Received Yes No if no why \_\_\_\_\_

Insurance ID Received Yes No if no why \_\_\_\_\_