Personal Insurance Intake Form

Patient Information

Date: _____ Date of Birth: ____/____/____
Name: _____ Social Security: ___-___-____
Address: _____
Street City State Zip

Email Address: _____
Home Phone: _____ Sex: M or F
Work Phone: _____
Cell Phone: _____ Height: ____" Weight: _____ lbs
Occupation: _____ Marital Status: _____
Employer: _____ Number of Children: _____
Employer Address: _____
Street City State Zip
If under 18 years, name of Parent or Guardian: _____
Emergency Contact: _____ Relation: _____
Emergency Contact Phone Number: _____

PCP Name: _____ **Phone**: _____

How did you hear about Capital Physical Therapy? __Website __Gym member
__Friend/Former Patient_____ __Drive By __Yellow Pages
__Moneysaver __Doctor: _____

Injury Information:

Why are you seeing the Physical Therapist today? _____
When did your injury occur (when did you start experiencing symptoms)? _____

Insurance Information:

Insurance Company: _____ Policy Holder Name: _____
Coverage: _____
Deductible _____ Has it been met? **Y** **N** Co-pay: $____

Patient Signature: _____ **Date:** _____

OFFICE USE:
Date Insurance Verified: _____ Rep Name: _____
Pre-Authorization: _____ Rep Phone (ext): _____
Limitations (per injury, lifetime, calendar year): _____
Initials: _____