

THRIVE PHYSICAL THERAPY INTAKE FORM

MR# _____

ICD-9 _____

APT. DATE: _____

Patient Information (Confidential)

Name _____ Home Phone _____

Social Security # _____ Male Female Birthdate _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

Patient or Parent/Guardian's Employer _____ Work Phone _____

Spouse or Parent/Guardian Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone # _____

Injury Information

Referring Physician _____ Phone # _____

Date of Injury _____ Surgery date _____ Diagnosis _____

Medicare Patients

PLEASE INFORM US IF YOU ARE CURRENTLY ALSO RECEIVING HOME HEALTH CARE. YOU WILL BE LIABLE FOR PHYSICAL THERAPY SERVICES IF THIS OCCURS. _____ INITIALS

Responsible Party

Name of Person Responsible for this Account _____ Relationship to patient _____

Address _____ Home Phone _____

Birthdate _____ SS# _____ Cell Phone _____

For your convenience, we offer the following methods of payment. **Co-pay payment in full at each appointment.** Please check the option you prefer.

Cash Personal Check Visa MasterCard I wish to discuss the office's payment policy

Insurance Information

Primary Insurance Company _____ ID# _____ Group # _____

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# _____ Name of Employer _____

How much is your deductible? _____ Do you have a copay? Yes No Amount? _____

DO YOU HAVE ADDITIONAL INSURANCE? Yes No **IF YES, COMPLETE THE FOLLOWING:**

Secondary Insurance Company _____ ID# _____ Group # _____

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# _____ Name of Employer _____

How much is your deductible? _____ Do you have a co-pay? Yes No Amount? _____

Work or Auto Related

Name of Insurance Company _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Claim # _____

Adjuster's Name _____ Adjuster's Phone _____

Nurse Case Manager's Name _____ Adjuster's Fax _____

Phone # _____

Fax # _____