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_____

Patient Employer _____ Work Phone_____

Person to contact in case of emergency_____ Phone #_____

Injury Information

Referring Physician _____ Phone # _____

Date of Injury _____Surgery date_____ Diagnosis _____

Responsible Party

Name of Person Responsible for this Account_____Relationship to patient_____

Address_____Home Phone_____

Birthdate_____SS# _____ Cell Phone _____

Co-pay is due in full at each appointment.

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? _____

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

Work or Auto Related

Name of Insurance Company _____

Address_____ City_____ State_____ Zip _____

Phone # _____ Fax #_____ Claim #_____

Adjuster's Name _____ Phone # _____ Fax # _____

Nurse Case Manager _____ Phone # _____ Fax # _____