Patient Intake Demographic Sheet Date completed: Appt Date/Time: PT:

Reminder: Ask about referring Dr. and Insurance first

First Name: _____ M.I _____ Last Name:_____
DOB: _____ Gender: ☐ M ☐ F SS# _____
Home Phone:_____ Work Phone:_____ Cell Phone: _____
Address: _____
Email: _____ Emergency Contact: _____ Phone: _____

Employment: ☐ FT ☐ P/T ☐NA ☐Student ☐Retired Occupation: _____
Name of Employer/School: _____

Referring /Primary Care Physician: _____ Phone: _____ ☐ New ☐ Optimis
Medical Group: _____ Fax: _____
Address**:** _____
Specialty: _____ Credentials: _____NPI: _____
Whom may we thank for referring you to our office? _____
_____
DX/Chief Complaint: _____
Did you have surgery? ☐ No ☐Yes Date: _____ Date of Onset:_____
How did injury occur: ☐MVA ☐WC Injury ☐Other: _____ Date: _____
Have you had/are you having home health care? ☐ Yes ☐ No Date of Discharge: _____
Have you previously had physical therapy for this diagnosis? ☐ Yes ☐ No #Visits/Details: _____

MVA / Worker Compensation: Claim #: _____
WC or Auto (PIP) Insurance Company: _____
Adjuster/Case Manager Name: _____ Phone: _____
Claims Mailing Address: _____ Fax: _____

INSURANCE COVERAGE

☐ No insurance / Prompt Pay

PRIMARY Insurance Company: _____
ID#: _____ Group#: _____ Effective Date: _____
Subscriber Name: _____ Relationship: _____ DOB: _____
Insured Party Employer: _____ Insured SSN: _____
Claim Address: _____ Phone: _____

SECONDARY Insurance Company: _____
ID#: _____ Group#: _____ Effective Date: _____
Subscriber Name: _____ Relationship: _____ DOB: _____
Insured Party Employer: _____ Insured SSN: _____
Claim Address: _____ Phone: _____

(Initial as Complete) Intake: Optimis: InsVer: Chart: 2016 MDCR 1951