

Appt Time ___/___/___

Therapist: **Referral Intake Form**

Patient: Last Name: _____ First: _____ DOB: ___/___/___
Address: _____ May we call you at home? Yes/No () _____
City: _____ Zip _____ Sex: M / F SSN _____ - _____ - _____
Alternate/Confidential Phone #() _____

Employer: _____ Occupation: _____
Address: _____ May we call you at work? Yes/No () _____
City: _____ Zip _____ Emergency Contact/Name: _____
() _____

Primary Physician: _____ Phone: () _____
Address: _____ Fax: () _____
City: _____ Zip _____

Referring Physician: _____ Phone: () _____
Address: _____ Fax: () _____
City: _____ Zip _____

Insurance Information

Primary Ins: _____ Code: _____ 2nd Ins: _____ Code: _____
Insured: _____ Insured: _____
Insured Employer: _____ Insured Employer: _____
DOB: ___/___/___ SSN: ___/___/___ DOB: ___/___/___ SSN: ___/___/___

Insurance Address: _____ Insurance Address: _____
Phone: () _____ Phone: () _____
ID#: _____ Group#: _____ ID#: _____ Group#: _____

Guarantor Information

Guarantor: _____ Relation: _____ SSN: ___/___/___
Address: _____
May we call you at home? Yes/No Phone:() _____ May we call you at work? Yes/No Phone:() _____
Accident Related? Yes/No Adjuster: _____ Phone: () _____

Worker's Compensation

Worker's Comp: YES/ NO _____ DOI: ___/___/___ Was it Reported? Yes No
Address: _____
Phone: () _____ Fax:() _____ Claim# _____
Contact: _____ State where filed? _____
Case Manager: _____ Case Manager Phone: _____ Case Manager Fax: _____

Insurance Verification

Body Part: _____ DOI: ___/___/___ Ins. Verification Contact: _____
Auth/Ref# _____ Exp. Date ___/___/___ # of Treatments _____
Billing Attachment Required: _____ Letter of Necessity _____ Prescription _____ Copay _____
Effective Date: _____ Max Out of Pocket \$: _____ Deductible:\$ _____ Max Visits _____

How did you hear about us? Physician Insurance Yellow Pages Rehab Nurse Friend Other: _____
Is the above information correct? Yes/ No Patient Signature: _____

Office Use Only

Intake _____
Check In _____
Insurance _____