Performance
THERAPIES, P.C.
Get results.

PATIENT INTAKE FORM

PATIENT INFORMATION

First Name:	**Last Name:**	**MI:**	**Date:**
Address:		**City:**	
State:	**Zip:**	**SS#/Driver's License #**	**State Issued:**
Birth Date:	**Age**	**Male Female**	**Maritial Status:**
Email Address		**Do you want email reminders? YES NO**	
Home Phone:	**Cell Phone:**	**Work Phone:**	
Billing Address:			
City:	**State:**	**Zip:**	

How did you hear about us? Circle those that apply

I was a former patient	Friend/Family/Word of Mouth	Physician Referral
Television/Radio Ad	Internet Search	Insurance Provider List
Performance Health & Fitness	School Coaches/Athletic Trainer	Clinic Sign

Other:_____

Can we leave medical or billing information on your voicemail: **Any Exceptions:**

Whom may we discuss your medical/billing information with: (ex. Mother/wife/coach,etc.)

WORK INFORMATION

Employer:	**Employer Address:**
Occupation	**Employment Status:** **Full Time Part Time Retired Not Employed**

IF PATIENT IS UNDER 18 OR LIVING WITH PARENTS

Father's Full Name:	**Father's Address:**	**Father's SSN/Driver's License #**	**Father's Phone Number**
Father's Employer:	**Employer Address:**	**Father's DOB:**	**Father's Work Number:**
Mother's Full Name:	**Mother's Address:**	**Mother's SSN/Driver's License #**	**Mother's Phone Number**
Mothers's Employer:	**Employer Address:**	**Mother's DOB:**	**Mother's Work Number:**

INSURANCE INFORMATION (PLEASE GIVE INSURANCE CARD TO THE RECEPTIONIST)

Primary Insurance Name:

Subscriber's Name (if different): **DOB:**

Patients's Relationship to Subscriber: **Self** **Spouse** **Child** **Other:**_____

Secondary Insurance Name:

Subscriber's Name (if different): **DOB:**

Patients's Relationship to Subscriber: **Self** **Spouse** **Child** **Other:**_____

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MEDICAL HISTORY	
Have you been seen by another Physical Therapist for this condition or another condition in *this* calendar year?	
If YES - Name of Facility where you were treated:	Number of visits:
Please list any other medical conditions you are being treated for:	
Please list the name of your Primary Care Physician:	
Please list the name of your Referring Physician:	
Please list any medications you are currently taking:	

AUTO OR WORK INJURY CLAIM (PLEASE PROVIDE PRIVATE INSURANCE INFORMATION)			
Auto:	Work Comp:	Employer:	
Adjuster/Claim Manager:	Phone:	Fax:	
Address:	City:	State:	Zip:
Claim #	Accident Date:	Cause:	

ATTORNEY INFORMATION			
Name:	Law Firm:	Phone:	
Address:	City:	State:	Zip:

HIPPA-PRIVACY PRACTICES

I, _____, have read through the Notice of Privacy Practices from Performance Therapies, P.C.

CONSENT FOR CARE AND TREATMENT

I, the undersigned, for myself or a minor child or another person for whom I have authority to sign, hereby consent and authorize Performance Therapies, P.C., its agents, associates and employees, to provide care and treatments to me per program policy and/or as prescribed by my physician. A representative of Performance Therapies, P.C., will explain my plan of care and answer my questions. I understand that the care plan may change and, if so, these changes will be discussed with me. I agree to notify Perormance Therapies, P.C., my physician or others providing care of any adverse reactions or other significant events relating to my health. I acknowledge that no guarantees have been made to me as to the effect of such examination or treatment of my condition by Performance Therapies, P.C., its agents associates and employees. I understand and agree that the terms of this financial policy may be amended by the practice at any time without prior notification to the patient/guarantor.

Signature:_____

Date:_____