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	Marital Status:
Email Address	Do you want Appointment reminders? Text Voicemail Email		
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.)

EMERGENCY CONTACT

Name: Relation:

Phone:

WORK INFORMATION

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

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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
Mother's Employer:	Employer Address:	Mother's DOB:	Mother's Work Number:

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:	

INSURANCE INFORMATION (PLEASE GIVE INSURANCE CARD TO THE RECEPTIONIST)					
Primary Insurance Name:					
Subscriber's Name (if different):					DOB:
Patients' Relationship to Subscriber:	Self	Spouse	Child	Other:_____	
Secondary Insurance Name:					
Subscriber's Name (if different):					DOB:
Patients' Relationship to Subscriber:	Self	Spouse	Child	Other:_____	

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: