PATIENT INTAKE

Personal details

First name (Legal): _____ Last Name (Legal):_____

Date of Birth: _____ Name Preference:_____

Gender on your ID or Insurance card: ○Male ○Female

Is your gender identity different from what is listed on your ID?

○Yes, what are your preferred pronouns? _____

○No

Contact details:

Address:_____

Address 2 (Apt. Suite, building, etc.)_____

City_____ State _____ Zipcode _____

Mobile phone: _____ Home phone _____

Please select how you prefer to receive statements:

○Mail ○Email ○Mail and email

How did you hear about us?

○Physician ○Google ○Facebook ○Former/Current Patient ○Word of Mouth

Emergency Contact:

Name:_____ Relation:_____Number:

_____

Payment details:

Are you using insurance?

◯ Yes, I am using insurance.

◯ No, I am NOT using insurance

Subscriber of insurance policy if not yourself:

First name (Legal): _____ Last Name (Legal): _____

Date of Birth: _____

Address (if different from patient):

_____

Insurance information:

Insurance (type, Aetna, BCBS, Medicare etc.):

Insurance member ID:

Patient relationship to insured (Self, spouse, child, other)

Secondary insurance (if applicable)

Secondary insurance member ID (if applicable)

Patient relationship to insured (Self, spouse, child, other)

Injury details:

Relevant injury dates:

What date did you first experience symptoms related to your injury?

If you had surgery for this issue, what was the date of the most recent surgery?

If you started treatment at another facility on an earlier date, please add that date here.

Please state what bodypart is injured and you are interested in getting treated

On what side of the body is your injury/condition?

○ Right ○ Left ○ Bilateral ○ N/A

Is your injury work related?

○ Yes ○ No

Is your injury Auto related?

○ Yes ○ No

Did a doctor/provider refer you to treatment?

○ Yes, Referring Provider Name:

○ No

Patient reported issues:

Describe how your condition came to be. What events occurred? When did the symptoms start? How has it progressed over time?

What is the main reason you are seeking medical attention? What problem can we help you solve?

Medical History:

Please list any medications you are currently taking with the name, dosage, frequency and the method you take it:

Please list any known allergies that you have: