Patient Intake Form

Consent to Release ☐ HIPAA ☐ Policy and Procedure ☐

Patient Name: ____ Date: __________________

Sex: _________________ DOB: ________________

Address: ____

City: ____ State: _______ Zip:____________________

Guardian: ____

Phone: ______________________________________ Cell: _________________________________

Email:____

Referring Physician: ____

Address: ____

City: ____ State: _______ Zip: ____________________

Phone: ______________________________________ Fax: _________________________________

Private Insurance: ____

Insurer: ______________________________________ Employer: ___________________________

Patient Relation: _________________________ Sex: _____________ DOB:__________________

Group #:_______________________________ Member #__________________________________

Claim Address: ____

City: ____ State: _______ Zip:____________________

Phone: ______________________________________ Fax: _________________________________

Medicaid/Managed Care Name: __________________________Medicaid #:_______________________

Early Interventionist Name: ____

Agency: ________________________________Phone:_________________Fax:_____________________

Is the patient currently being treated by an occupational or physical therapist? YES ☐ NO ☐

If yes, please indicate where and how often ____