

Patient Intake Form

Patient Name _____ Birth date ____ / ____ / ____ Male ___ Female ___

Address _____ City _____ State ___ Zip code _____

Home number () _____ wk/cell number () _____ SSN _____

Diagnosis/problem _____ Onset of injury _____

Occupation _____ Employer _____

Marital status S M D O Emergency contact person _____ ph () _____

Physician Information

Referring physician _____ ph () _____ fax () _____

Primary care physician _____ ph () _____ fax () _____

Insurance Information (please check one)

Were you in a car accident? yes no Were you hurt at work? yes no

Is this a personal injury case involving an attorney? yes no

(If yes, please provide the attorney name and phone number) _____ ph () _____

Primary Insurance _____ Subscriber name _____

Subscriber birth date _____ Subscriber SSN _____

Relationship to patient _____ ID# _____ Group # _____

Claims address _____ Claims ph# () _____

Auto claim # _____ WC claim # _____

Secondary Insurance _____ Subscriber name _____

Relationship to patient _____ ID# _____ Group # _____

Claims address _____ phone # () _____

How did you hear about Personal Best performance? _____

I hereby authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits to the supplier for services rendered. I further agree that should the amount be insufficient to cover the entire medical expense, I will be responsible for payment of the entire bill.

Signed _____ Date ____ / ____ / ____

For Office Use Only

Deductable _____ Deductable met _____ % Insurance covers _____ Insurance co-pymt _____

Is there a max # of visits per year? yes no If yes, how many? _____ Durable goods coverage _____

Effective date of coverage _____ Date verified ____ / ____ / ____ Time _____ Contact person _____

Do you require: Prescription from physician Letter of medical necessity