

Sports Physical Therapy Institute Patient Intake Form

Date _____ Birth Date _____ Patient Name _____ Address _____ City/State/Zip Code _____ Phone # _____ E-Mail _____ Emergency Contact/Relationship _____	Social Security Number _____ Employer _____ Business Phone _____ Occupation _____ Marital Status _____ Driver's License #/State _____ Phone # _____	
Primary Insurance _____ Policy Holder _____ ID Number _____ Do you have any other insurance policies _____ Are you currently a full time student? YES ___ NO ___ School _____	Secondary Insurance _____ Policy Holder _____ ID Number _____	
Is this injury the result of an accident? ___Auto ___Work ___School ___Other _____ Date of Accident _____ State where accident occurred _____ Is this accident in litigation? YES ___ NO ___ Will you be submitting any of your medical bills to the accident insurance? YES _____ NO _____ Insurance Company _____ Claim # _____ Adjustor's Name _____ Adjustor's Phone # _____ Address _____		
Referring Physician _____ Phone Number _____ Primary Care Physician _____ Phone Number _____ Date of Injury _____ Have you had surgery? YES ___ NO ___ N/A ___ Surgery Date _____ Have you had Physical Therapy this calendar year? YES ___ NO ___ How many visits? _____ How did you hear about Sports Physical Therapy? Friend Family Doctor Other _____ Are you presently under the care of an Athletic Trainer? YES ___ NO ___ If yes, school/ ATC name _____		
I certify the above information is correct to the best of my knowledge. I understand that I am financially responsible for all charges whether or not covered by insurance. I also understand that if charges are allowed but not covered by my insurance company, I will be responsible for payment in full of any of these charges, as well as any co-payments, deductibles and/or supply purchases. I authorize treatment by the physical therapist at Sports Physical Therapy Institute, P.A. Initial _____ Date _____		

I authorize Sports Physical Therapy Institute, P.A. to charge my Visa or MasterCard for any charges incurred during my treatment. These charges may include, but are not limited to, co-pays, co-insurance, deductible or supplies.

*We process **VISA** and **Master Card** only.*

Type of Card _____ Name as it appears on the Card _____

Credit Card Number _____ Exp. Date _____

Signature _____ Date _____

YOU HAVE THE RIGHT TO COPY THIS DOCUMENT