promotion THERAPY SERVICES

NEW PATIENT INTAKE FORM

PATIENT NAME: (L, F, MI)	PATIENT #:
ADDRESS:	EMAIL:
CITY:	FIRST VISIT:
STATE: ZIP:	REFERRING PHYSICIAN: PCP PHYSICIAN:
DOB: _____ ___MALE ___FEMALE	DIAGNOSIS: TYPE OF INJURY : WORK____ PERSONAL___ AUTO___
SSN:	INJURY/SURGERY DATE:
HOME PHONE:	NEXT APPT. W/ PHYSICIAN:
WORK PHONE:	HAVE YOU HAD PT THIS YEAR? IF YES, WHAT AREA?
EMPLOYER:	HAVE YOU HAD ANY CHIROPRACTIC VISITS THIS YEAR?
EMERGENCY CONTACT: RELATIONSHIP:	PHONE:
PRIMARY INSURANCE:	DEDUCTIBLE: IN NETWORK OUT OF NETWORK MET
POLICYHOLDER NAME:	CO PAYMENT/ IN NETWORK OUT OF NETWORK MET COINSURANCE:
RELATIONSHIP TO INSURED: ___SELF ___SPOUSE ___CHILD	OUT OF POCKET: IN NETWORK OUT OF NETWORK MET
POLICYHOLDER DOB/SS#:	EFFECTIVE DATE: VISIT LIMIT: VISITS USED:
ID/CONTRACT # W/ ALPHA PREFIX:	
GROUP #	PRECERT: ____ YES ___NO
EMPLOYER:	REFERRAL: ____YES ____NO
INSURANCE PHONE #:	SPOKE TO: DATE:
SECONDARY INSURANCE:	DEDUCTIBLE: IN NETWORK OUT OF NETWORK MET
POLICYHOLDER NAME:	CO PAYMENT/ IN NETWORK OUT OF NETWORK MET COINSURANCE:
RELATIONSHIP TO INSURED: ___SELF ___SPOUSE ___CHILD	OUT OF POCKET: IN NETWORK OUT OF NETWORK MET
POLICYHOLDER DOB/SS#:	EFFECTIVE DATE: VISIT LIMIT: VISITS USED:
ID/CONTRACT # W/ ALPHA PREFIX:	
GROUP #	PRECERT: ____ YES ___NO
EMPLOYER:	REFERRAL: ____YES ____NO
INSURANCE PHONE #:	SPOKE TO: DATE: