Demographic Intake Form

Patient information:

First name: ________________________MI:______ Last Name: ________________________

Nickname (Alias): ________________________ Gender: ☐Male ☐Female

DOB: __________________________ SS#: ___________-________-___________

Mailing Address: ____

____

City/State/Zip ____________________________________/_______/_________________

We use an Automatic Dialing/Messaging System to send reminder notifications of your appointments. By selecting a box below, you are consenting to receive emails, phone calls or texts at the email address or phone number provided. If using a wireless service, your carrier may charge you for such calls. You may opt out of this service at any time by notifying our office.

☐Please do not remind me of my appointment

Reminder Preference: Please choose only one - but fill out info for all.

☐Email: ____

☐Home phone: ____

☐Cell phone: ☐TEXT or ☐CALL ___________________________________

Work phone: _____________________________________Ext: ______________

Parent/Guardian/Guarantor Information (if different than patient)**:**

First name: ______________________ MI: _____ Last Name: ______________________

Relationship to patient: ____

Address: ____

City/State/Zip ___________________________________/__________/________________

Emergency Contact:

Name: ____

Relationship to patient:_________________________ Phone #:_________________________

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Episode Form

Medical Information for this episode of care:

Referring physician: ____________________ Primary Care physician: _________________

What part of your body will we be treating? ____

When did your symptoms start, or date of your injury? ________________________________

If you've had surgery for this, what was the date of your most recent surgery? _____________

Injury Related To: ☐ Employment ☐ Automobile accident/State of accident ______ ☐ Other

Worker's Compensation: (If work related injury please list info below)

Employer: ____________________________________

Employer address: ______________________________

Supervisor: ___________________________________ phone #: __________________

Work Comp. Insurance: ____

Case Manager/Adjuster: ____

Claim #: ______________ If unable to work, list last full work date: _______________

Insurance information: (Please allow us to make copies of your insurance cards)

Primary Insurance: ______________________ Secondary Insurance: ___________________

Patient's relationship to insured: ☐ Self ☐ *Spouse ☐ *Child

*If not, "self" please list Insured's Name _________________________ DOB: _______

Insured's SS#: ______-_____-_____ Phone: __________________ ______________

Insured's Address: ____

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