Comprehensive Therapy Solutions

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PATIENT INTAKE FORM

INTAKE DATE ____________ APPT DATE ______________

PATIENT INFORMATION

PATIENT NAME (FIRST, MI, LAST)	SSN	SEX M / F	DATE OF BIRTH	AGE
HOME ADDRESS	CITY	STATE	HOME PHONE	
PATIENT EMPLOYER	OCCUPATION		BUSINESS PHONE	
EMPLOYER ADDRESS	CITY	STATE	ZIP CODE	
SPOUSE OR PARENT NAME	EMERGENCY CONTACT NAME		EMERGENCY CONTACT PHONE	

DIAGNOSIS / INJURY

DIAGNOSIS		DATE OF INJURY
REFERRING PHYSICIAN NAME	REFERRING PHYSICIAN ADDRESS	PHONE

INSURANCE INFORMATION

PERSON RESPONSIBLE FOR PAYMENT (if not patient)				ADDRESS	
CITY	STATE	ZIP	PHONE	MEDICARE ID NUMBER	MEDICAID ID NUMBER

PRIMARY INSURANCE	ID NUMBER	GROUP NUMBER	INSURED SSN
PRIMARY INSURANCE ADDRESS	CITY	STATE	ZIP CODE
SECONDARY INSURANCE	ID NUMBER	GROUP NUMBER	INSURED SSN
SECONDARY INSURANCE ADDRESS	CITY	STATE	ZIP CODE

VERIFICATION

DATE	CONTACT NAME		CONTACT PHONE	
DEDUCTIBLE	AMOUNT MET	MAX VISITS ALLOWED	OUT OF POCKET MAX	CO-PAY
REFERRAL REQUIRED Y / N	PRE-CERTIFICATION REQ'D Y / N	AUTHORIZATION NUMBER		

REVERIFICATION: ____

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