Central Mountain Physical Therapy Intake Form

**Name:	**MD or Direct Access:
**DOB:	**Diagnosis:
**Home Phone and Cell:	Date of Surgery:
PO Box (must provide street address also):	**Primary Insurance: (Please Make Photocopy of All Cards)
Street Name:	ID Number (Must have Soc. Sec. # for VA patients):
City:	**Name of Policy Holder (Please circle: self / spouse / parent)
State & Zip:	**Insured's Date of Birth:
Emergency Contact Name:	Emergency Phone #:
Email Address:	Do you have a Secondary Insurance? If yes, Who carriers the policy, their DOB, Policy Name and ID #?

Office Use Only: Auth: _____ Visits/Cal: _____ Visits Used: _____ Medicare Cap: _____ Copay: _____

Is this a Work-Related Injury or Auto Claim? (Note: Must still obtain regular health ins info above)	No Yes (Provide Injury Date "Matching" Claim)
Work Comp or Auto Carrier Name:	Claim #:
Name & Address of WC Employer:	Contact Name for Claim:

Name of Employer or School:	FT PT Student Retired Unemployed
Circle what your symptoms are the result of? ** If Unknown or Chronic Condition, note approx. onset date of current symptoms	Surgery Work/Auto Accident Sports Injury Fall Unknown or Chronic Condition -- Approx. Onset Date:
Have you had any PT or Chiropractic Services this Calendar Year?	No Yes
Have you Received any Home Health or Inpatient Rehab Services this Calendar Year?	No Yes (Please Provide Name of Agency…We must call to obtain Official Discharge Date)