Lewy Physical Therapy Patient Intake Forms

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY, PAYING SPECIAL ATTENTION TO ALL HIGHLIGHTED AREAS

Patient First Name________________________________ Middle Initial____ Last Name_____________________________

Home Phone (____) __________________ Cell Phone (____) ________________ Work Phone (____) _________________

Please specify which number you would prefer us to call: o Home o Cell o Work (CHECK ONE)

Please check the type of reminder you would like for your appointments:

o text ____________________ o phone call ____________________ o email ________________________________

Birth date________/_________/_________ SSN______________________________ **(Mandatory for Billing)** Male Female

Mailing Address ____________________________________City______________________ State_______ Zip_________

Check appropriate response: o Minor o Single o Married o Divorced o Widowed

Patient's Employer____ Work Phone (___) ____________________

Employer Address____ City___________________State______Zip________

Has the patient received any type of physical/occupational or home health therapy within the current calendar year?

(for this injury or any other injury) YES / NO IF YES, PLEASE INFORM YOUR THERAPIST

Are you currently receiving Home Health ? o **YES** o **NO** **If yes, have you been discharged?** o **YES** o **NO**

How did you hear about us? ____

Referring Physician__________________________________ Primary Care Physician _______________________________

Emergency Contact Information

Contact name____ Relationship to patient: ___________________________

Phone Number ______________________________________ Alt Phone Number ______________________________

Was this condition related to an accident or injury? (CHECK ONE) o **YES** o **NO**

If yes, what type: o Auto o Injured at work o Other: ____

Date of accident or injury__________ Accident Details____

If this condition is related to an accident, please supply any third party payor information----attorney, car insurance company name/phone/claim #, etc.

Attorney/Adjuster Name______________________________________ Phone # (___) _____________________________

Claim Carrier (Auto/WC) ____________________________________ Claim #:__________________________________

If patient is under the age of 18, please complete this section.

Parent's Name ____________________________ Parent's DOB: ________________ Parent's SSN: _____________________

Employer ________________________________Work phone (____)_____________

If patient is a student, name of school/college________________________________ City___________________ State_____

By signing below, you agree that the information provided above is considered accurate to the best of your knowledge. Should circumstances occur that change any of the information you have previously provided above, please inform our Front Desk staff immediately. Thank you.

____ ____________________________

Patient/ Authorized Representative Signature Date