Lewy Physical Therapy Intake Paperwork

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY

Patient First Name_____ Middle Initial____ Last Name_____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

Email Address: _____

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 (___) _____

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 _____

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

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