PATIENT INTAKE FORM

Print Intake Form

Patient Information

First Name _____ MI ___ Last Name _____ DOB ___/___/____

Address _____ City _____ State _____ Zip _____

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

◯ Male ◯ Female Social Security# _____-____-_____ Email _____

Parent Name _____ Address _____ Phone (___) ____-_____
(If Applicable) (If different than above)

Emergency Contact

Name _____ Relationship _____ Phone (____) _____-_____

Employer

Name _____ Phone (____) _____-_____

Address _____ City _____ State _____ Zip _____

Problem

Injury/Body Part _____ Date of Surgery ___/___/____ Have you had previous PT or OT this Year? ◯ Yes ◯ No

Referring Provider _____ Primary Care Physician _____ Last MD Visit ___/___/___

How did you hear about us? ◯ Health Care Provider ◯ Friend/Relative ◯ Radio ◯ Other _____

Insurance Information

◯ L&I Claim ◯ Worker's Comp/Self-Ins Claim Date of Injury ___/___/____

◯ Motor Vehicle Accident Available P.I.P? ◯ Yes ◯ No Date of Injury ___/___/____ Place of Accident _____

Responsible Party _____ Phone (____) _____-_____

Adjuster/Claim Manager's Name: _____ Phone (____) _____-_____

Primary Insurance Information	Subscriber Name on Card	Subscriber Information
Insurance _____	Name _____	Subscriber Address _____
ID/Claim# _____	Relationship to patient _____	_____
Group# _____	Date of Birth ___/___/_____	Subscriber Phone (___) ____-_____
Phone _____	◯ Male ◯ Female	

Secondary Insurance Information	Subscriber Name on Card	Subscriber Information
Insurance _____	Name _____	Subscriber Address _____
ID/Claim# _____	Relationship to patient _____	_____
Group# _____	Date of Birth ___/___/_____	Subscriber Phone (___) ____-_____
Phone _____	◯ Male ◯ Female	

Consent for Treatment, Assignment of Benefits, & Release of Information: I hereby authorize you to evaluate & treat me (or my dependent) and I assign directly to Rainier Physical Therapy all medical insurance benefits, if any, for services rendered.

I hereby authorize the release of all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. A photocopy of this document is considered as valid as the original.

Signature _____ Date _____
(Parent or Guardian if patient is a minor)