NOW physical therapy

PATIENT INTAKE FORM

Patient Name: ____ Date of Birth: __________________________

Legal Guardian (if applicable): ___________________________________Email: _________________________

Home Phone: _________________________________Cell Phone: ___________________________________

Address: ___________________________________ City/State: _______________________ Zip: _________

Referring Physician (if available): _____________________________ Phone Number: __________________

Diagnosis or Why you are seeking PT: ____

Have you seen a PT for this diagnosis recently? Y N If so, where?_____________________________

PRIMARY INSURANCE INFORMATION

Insurance Company: ____

Primary Insured Name: ____ Date of birth: ______________

Member ID: ____ Group: ___________________________

*Please provide copy of front and back of insurance card.

FOR NOW PT TO COMPLETE:

Annual Deductible: ind/fam______________________________ How much met?______________________

Max out of pocket? Ind/fam ____ Met? Y N

Copay: _________________

Provider Phone Number (on back of card): ____