Holsman Physical Therapy and Rehabilitation PC Intake Form

Office Use Only

Past Patient: ☐ **YES** ☐ **NO**	Evaluation Date: Date of prescription:		☐ PT ☐ OT ☐ ST ☐ Other
Diagnosis 1 (Desc/ICD9):	Diagnosis 2 (Desc/ICD9):	Onset Date:	

Patient Information

Patient Name: (First, MI, Last, - Sr., Jr., etc)		SS #: - -	
Address:	City	State:	Zip Code:
Telephone:	Date of Birth (mm-dd-yyyy)	Sex: ☐ M ☐ F	Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Unknown
Date of Injury / Onset Date	Auto Related: ☐ Yes - State? ________ ☐ No	Work Related: ☐ Yes ☐ No	Adjustor Name & Telephone #:

If Workers Comp, was accident with present Employer?
☐ Yes ☐ No If No, who was employer? ________________________________
Occupation: ____

If Auto Accident: Date of Accident: ____ / ____/ ____
Type of Accident: Driver / Passenger / Pedestrian / Job / Fall / Other

How did you hear about us? ☐ **Website** ☐**Google** ☐**Yelp** ☐**Yahoo** ☐**Angie's list** ☐**Doctor's office** ☐**Flyer** ☐**Mail** ☐ **Other**_____________________

Who should we thank for this referral?

Do you have Medicare? ☐ **No** ☐ **Yes**
Are you currently receiving Home Health Services? ☐ No ☐ Yes
If Yes, name of agency & what type of Home Health Services are you receiving? ________________________________
If No, have you received services in past 60 days ______If yes, Name of Agency & last Date of Service________________________________
Were you ever treated for Out Patient Physical Therapy before? ☐ No ☐ Yes IF Yes, last Date of Service__________________________

Primary Insurance Information

Name of Insurance Company:	Policy or Claim #:	Group # / Policy Holders Employer:
Policy Holder Name:	Date of Birth:	Social Security #
Insurance Company Telephone #:	Policy Holders Work Phone #:	**Patient Relationship to Policy Holder:** ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Secondary Insurance Information (Backup if Auto, Workers Comp. or Litigation)

Name of Insurance Company:	Policy or Claim #:	Group # / Policy Holders Employer:
Policy Holder Name:	Date of Birth:	Social Security #
Insurance Company Telephone #:	Policy Holders Work Phone #:	**Patient Relationship to Policy Holder:** ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Employer Information

Employer Name:	Employer Phone #:	Employment Status: ☐ None ☐ FT ☐ PT ☐ Self-Emp. ☐ Retired ☐ Student	
Address:	City	State:	Zip Code:

Emergency Contact Information

Contact Name:	Phone #	Relationship to Patient: ☐ Parent ☐ Spouse ☐ Sibling ☐ Other

Physician Information

Name of Referring Physician:	Telephone #:		
Address :	City	State:	Zip Code:

Attorney Information

Attorney Name:	Attorney Phone #:	**Address:** ______________________ **City:** ___________ **State:** _________________ **Zip Code:** _______________

I _________________________________authorize Holsman Physical Therapy and Rehabilitation, PC to treat me as per my doctor's prescription/ Therapist's Plan of Care and to release to my Insurance company / Lawyer / Employer any information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating claims for benefits.

Date: _____________________________________ Signature: ____

If you would like to receive Holsman Physical Therapy and Occupational Therapy news, announcements and healthy tips, please include your e-mail address:
____ ***(Your email address will not be shared)***

PLEASE PROVIDE YOUR INSURANCE CARD TO COPY AND DRIVER'S LICENSE TO REVIEW

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