

Wheatfield Physical Therapy Intake Form

Mark Milleville PT Dan Tompkins PT

Name: _____ Date: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Beeper/Cell: _____

D.O.B.: _____ Soc Sec #: _____ Previous Therapy for this condition: **Y / N**

Are you **CURRENTLY** receiving any home care medical services?: **Y / N** If yes, agency: _____

Emergency Contact Name: _____ Phone #: _____

Referring MD: _____ Primary MD: _____

Employer: _____ Occupation: _____

Address: _____

City: _____ State: _____ Zip: _____

How did you hear about our facility? _____

Health Insurance Info

Carrier: _____ Ins Co. Phone: _____

Address: _____

Policy #: _____ Group #: _____

Patient Relationship To The Insured: Self Spouse Child Other

* If you are covered under another person's insurance, please complete.

Name of Insured: _____

Address of Insured: _____

Phone of Insured: _____ Sex: _____ D.O.B. _____

Auto Accident Insurance

Carrier: _____ Policy Number: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Person to Contact: _____ Claim #: _____

Date of Accident: _____ Patient Relationship To The Insured: Self Spouse Child Other

Workman's Compensation

Carrier name: _____ WBC case #: _____

Carrier Case# _____ Injury Date: _____

Phone #: _____ Contact Person: _____