

Please complete this intake form and print clearly so we may transfer your information to our medical database for proper claim submission.

The privacy and security of your personal health information is very important to us.

We will do our best to answer your questions in a professional and private manner.

Thank you for trusting us with your health care.

PATIENT INFORMATION

Today's Date: _____ / _____ / _____ Date of Birth: _____ / _____ / _____

Last Name: _____ First: _____ MI: _____ Nickname: _____

Address: _____ City: _____ State: _____ ZIP: _____

E-mail address: _____

Sex: Male Female Status: Minor Single Married Divorced Widowed

Driver's License Number: _____ State: _____ SS#: _____ - _____ - _____

Employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ ZIP: _____

Work Related Injury?: Yes No Auto Related Injury?: Yes No Date of Injury: _____ / _____ / _____

How did you hear about Physical Therapy Advantage? Website Neighbors Magazine Kane County Magazine
 Postcard Mailer Former Client Physician Insurance Friend/Relative Other

Whom may we thank for referring you?

In case of emergency, who should be notified? Name: _____ Relationship: _____ Phone: () _____ - _____

PREVIOUS ADDRESS IF LESS THAN TWO YEARS AT PRESENT ADDRESS

Address: _____ City: _____ State: _____ ZIP: _____

INSURANCE – Who is responsible for this account? If same as above you may leave blank. Please have your insurance card available for us to make a copy.

Insured Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ ZIP: _____

SS#: _____ - _____ - _____ Date of Birth: _____ / _____ / _____
