Westchase Physical Therapy & Medical Supply

PATIENT INTAKE FORM

First Contact Date:______________ Employee:____

SECTION 1 – GENERAL INFO (re-verify all info for completeness & accuracy)

Patient Name:__________________________________ M F Location (Circle One): Westchase Clearwater Lutz

Date of Birth (mm/dd/yyyy): ____ / ____ / ____ Email:____ Email sent on:______

How did you hear about us? (Circle one) Physician Prior Patient Online Other

Current Address:____City:_______________ State:___ Zip Code:___________

Contact Numbers: Primary:______________________ Secondary:_______________________ Tertiary:__________________

SECTION 2- PHYSICIAN v(re-verify all info for completeness & accuracy)

Referring Physician:_________________________________ Tel #:_______________________ Fax#:______________________

PCP (if other than referring Dr.):_________________________ Tel#:_________________________ Fax#:_____________________

Diagnosis:____ Do you have a Rx?: YES_____ NO_____

SECTION 3- INSURANCE (re-verify all info for completeness & accuracy – make sure all cards scanned)

Primary Insurance:_____________________________ ID#:___________________________________ Group#:_____________

Primary Insurance Provider Tel# (as indicated on card):_______________________ Type of Plan: PPO HMO GOV'T Other

Subscriber Name (if other than self):______________________________________ Subscriber DOB:________________________

Worker's Comp?:_____ Name of W/C Plan:_____________ Auto/PIP?:_____ LOP?:_____ OTHER:_____ DOI?:______

Claim #:_________________________ Claim Adjuster:____________________________ Adjuster Contact #:________________

Attorney Name:______________________________ Atty Tel #:_____________________________ Atty Fax:________________

Secondary Insurance:_____________________________ ID#:___________________________________ Group#:__________

SECTION 4- EMERGENCY CONTACT INFORMATION** **(patient to complete)

In case of Emergency please Contact:____

Phone(s):____ Relationship to Patient:____

I have reviewed this form and understand & agree with the information contained. My signature represents agreement with this information. The information I have provided to Westchase Physical Therapy & Medical Supply, LLC is complete and accurate to the best of my knowledge. I have not misrepresented myself, referring physician and/or payer source. I understand that my benefits are subject to verification. I understand that the Insurance's Explanation of Benefits "EOB" indicates serves as the definitive guideline for reimbursement, applicable co-pays, co-insurance, deductible, active coverage, etc and that I am subject to the parameters of my policy as determined by my insurance payer.

Patient Signature:___________________________________ ***Printed Name:***______________________________ ***Date:***________