LIFESTYLES PHYSICAL THERAPY INTAKE FORM

PATIENT INFORMATION			
Name:	Gender	DOB___/___/___	SSN____/___/_____
☐Home Phone# ( )	☐Work Phone# ( )	☐Cell Phone# ( )	
Current address:	Email:		
City:	State:	ZIP Code:	
Marital Status: ☐Married ☐Single ☐Divorced	Student Status: ☐Full time ☐Part time		
Employment Status: ☐Full time ☐Part time ☐Retired ☐Not Employed			
Employer name:	Occupation:		
Emergency Contact:	Phone # ( )	Email:	
☐ I permit Lifestyles Physical Therapy to leave detailed messages regarding my treatment and billing at the following location(s): (check all that apply) ☐Home Phone ☐Work Phone ☐Cell Phone ☐Email			
☐ I permit Lifestyles Physical Therapy to release treatment, billing, and scheduling information to the following people: Name:			

REFERRAL INFORMATION		
Referring Source:	Phone # ( )	
Primary Physician:	Phone # ( )	Fax # ( )

INJURY INFORMATION	
Injury Type: ☐Work ☐Auto ☐Other	Date Symptoms Began:
Diagnosis/Symptoms:	
Surgery:	Date of Surgery:

INSURANCE		
Primary Insurance Company:	Phone # ( )	
Policy of ID#	Group #	
Address:		
City:	State:	Zip:
Insured Name:	Phone # ( )	DOB
Relationship to Patient:	Policy Type: ☐Employer ☐Group ☐Individual ☐Other	
Secondary Insurance Company:	Phone # ( )	
Policy of ID#	Group #	
Address:		
City:	State:	Zip:
Insured Name:	Phone # ( )	DOB
Relationship to Patient:	Policy Type: ☐Employer ☐Group ☐Individual ☐Other	

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(For Office Use Only)

Effective Date:	Network: ☐In ☐Out	Pre-Auth Required: ☐Yes ☐No
☐ Deductible		Plan year: ☐Calendar ☐Other___/___/___ to ___/___/___
Deductible $		Deductible Met$

IN-NETWORK	Co-pay	Benefit %	Out-of-pocket-max
OUT-OF-NETWORK	Co-pay	Benefit %	Out-of-pocket-max

☐Referral from MD Required	☐Submit Chart Notes with Claim
Special Requirements:	
Spoke With:	Date:

WORKERS COMP/AUTO CLAIM INFORMATION

Claim#	Date of Accident:	
Insurance Company:	Adjuster:	Phone # ( )
Address:		
City:	State:	Zip:
Special Requirements:		
Spoke with:	Date:	

I authorize the release information necessary to process my insurance claims. I assign and request payment directly to my medical provider. To the best of my knowledge the information contained in this intake form is accurate and correct.

Signature:	Date: