Patient Intake Information

Front Range Therapies Castle Rock

Name_____ Date:_____

Address_____

City_____State_____Zip_____

Date of Birth_____ Age_____ Sex: M / F

Injury and/or Surgery Date:_____ Is this injury related to: work__ auto__ other__

Reason for visit/Injury Area:_____

Phone_(_____)_____□ Home□ Cell□ Work Other phone_____

□Yes □No May we call you at home?
□Yes □No May we leave a voicemail message if there is no answer?
□Yes □No May we leave a message with another person?
□Yes □No May we call you at work? __(____)_____

Email_____(for occasional newsletter and clinic updates)

SSN_____ Driver's License #_____

Employer_____Occupation_____

Referring physician_____

Who referred you to us, if not a physician?_____

Below is insurance information. Although we also have a copy of your insurance card, we ask that you please fill in this section as well. Completing this information demonstrates that you understand your insurance benefits and responsibilities. Insurance can only be billed if you fill out all the requested information. Thank you.

Health Insurance Company_____

Patient's relationship to insured: self_____ child_____ spouse_____ other_____

Medicare/Insurance ID#_____Group #_____

Insured's name if different from patient_____SSN_____

Insured's address_____Employer_____

Insured's DOB_____Phone_____

If auto/workers comp, claim #_____Claim adjustor/contact_____

Supplemental Insurance (if applicable)_____

Supplemental Insurance ID#_____Group #_____

Are you currently receiving Home Health Care? Yes / No (please circle)

Relative/Friend not living with you (contact in case of emergency)

_____

Emergency contact person's address_____

City_____State_____Zip_____Phone_(____)_____