Date:______________________ Eval Date / Time:___________________

Intake Questionaire

Patient: ____ DOB: _______________________ Gender: M F

Phone #: _________________________________ Email: ____

Address: ____

Medicaid #: _______________________________ SSN: ____

Referring MD: _____________________________ Dx: ________________________ Date of Script/Surgery: ______________

Emergency Contact Name: ____ Phone #: _________________________

Insurance Company: ____ AUTO WC

Adjuster/Contact: ____ Phone: ___________________________

Attorney: ____ Claim #: ____

Address to send claims: ____

Cash Pay Rate: Initial Evaluation: __________________ Follow-up Visits: _____________________

Terms of Agreements: The following terms are based on information given at the time verification. If you have any questions regarding the accuracy of these terms, it is the patient's responsibility to contact their insurance provider. If coverage claim is denied, patient is responsible for payment of services.

Patient Responsibility: ____

Sign: ____ Date: ______________________________