Optimal Physical Therapy Patient Intake Form

Patient Information		
Patient Name:	**E-Mail:**	**S.S#**
Address:	**City:**	**Zip:** **State:**
Home Phone: **Cell Phone:**	**Date of Birth:**	**Sex: Male Female**
Referring MD:	**Diagnosis:**	**Date of Injury:**
Primary Insurance Information		
Name of Insurance Company:	**Policy or Claim#:**	**Group#:**
Policy Holder Name:	**Date of Birth:**	**S.S.#**
Insurance Company Telephone:	**Policy Holders Work Phone:**	**Patient Relationship to Policy Holder** **□ Self □ Spouse □ Dependent □ Other**

□ NA	Secondary Insurance Information	
Name of Insurance Company:	**Policy or Claim#:**	**Group#:**
Policy Holder Name:	**Date of Birth:**	**S.S.#**
Insurance Company Telephone:	**Policy Holders Work Phone:**	**Patient Relationship to Policy Holder** **□ Self □ Spouse □ Dependent □ Other**

□ NA	Accident Information
Accident Date:	**Motor Vehicle Accident or Workers Comp**
Adjustors Name:	**Adjustors Phone#:**
Insurance Reps Name:	**Insurance Reps Phone:**
Attorney Name:	**Phone#:**

I_____, authorize Optimal Physical Therapy & Performance Institute to release my insurance company/ Lawyer/ Employer any information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating claims for benefits.

Date:_______________________________ **Signature:**____