CORNERSTONE
PHYSICAL THERAPY & BEHAVIORAL HEALTH

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Patient Intake Form

Patient Information

Name: _____ Date of Birth:_____

Address: _____ Age: _____

_____

Cell #_____ Work #_____ Home #_____

E-mail address: _____ (we will not share your e-mail address)

Please circle: Male Female

Please circle: Married Single Divorced Widow Widower

Please circle: Work full-time Work part-time Student Retired Disabled Other:_____

Employer: _____
Address: _____
Occupation: _____

Primary Care Physician Information

Name of your Primary Care Physician: _____
Address: _____
Phone Number: _____

Who referred you to our office: _____
Relationship: _____
Phone Number: _____

Visit Information

What is the reason for today's visit: _____

Is this a result from an accident?_____ If yes, please explain:_____
_____

Date you first noticed symptoms or injury date: _____

Insurance Information

Primary Insurance Carrier

Name: _____
Claims Mailing Address: _____
_____

Phone Number for Provider Services: _____
Member Identification Number: _____
Group Number: _____

Are you the policy holder for this plan: Yes_____ No_____
If no, policy holder's name: _____ Date of Birth: _____
Relationship to patient: _____
Policy Holder's Phone Number: _____

Secondary Insurance Carrier

Name: _____
Claims Mailing Address: _____
_____

Phone Number for Provider Services: _____
Member Identification Number: _____
Group Number: _____

Are you the policy holder for this plan: Yes_____ No_____
If no, policy holder's name: _____ Date of Birth: _____
Relationship to patient: _____
Policy Holder's Phone Number: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Cornerstone Physical Therapy. I understand that I am financially responsible for any balance. I also authorize Cornerstone Physical Therapy or the insurance company to release any information in processing my claims:

Patient/Guardian Signature: _____ Date: _____