Atlantis Physical Therapy Group, Inc.

Personalized Fitness Solutions to Enhance People's Lives
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Health Insurance Intake Form

Intake Date: _____ Interviewer: _____

BASIC PATIENT INFORMATION

First Name: _____ Last Name: _____ **M / F**

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone/Pager: _____ Date of Birth: _____

Social Security No: _____ License: _____

Email Address: _____

Marital Status: **Single** **Married** **Divorce** **Widow** **Separated**

EMPLOYMENT INFORMATION

Employer Name: _____

Occupation: _____ Tele #: _____

Are you missing time from work? **YES** **NO** (circle one)

How long? _____

HEALTH INSURANCE INFORMATON

Do you have Health Insurance? **YES** **NO** (circle one)

Name of Health Insurance Carrier: _____

Address: _____

Subscriber: _____ Card No: _____

Group No: _____ Exp. Date: _____

What are your major complaints: _____

_____

Primary Care Physician: _____

_____

Address: _____

Telephone No: _____

Referral obtained: YES NO

How many visits were approved: _____

_____

DESCRIPTION OF INJURY/ COMPLAINTS

Brief descriptions of injury/complaints please write below:

_____

_____

_____

_____

I understand and agree that Health and Accident Insurance policies are an arrangement between the insurance carrier and myself. I authorize payment from my Insurance Carrier directly to this office with the understanding that all monies will be credited to my account upon receipt.

Patient's Name: _____ Date: _____

Patients Signature: _____