DORSET PHYSIO 3155 Rt-30 Dorset, VT 05251 Phone 802-867-7056 Fax 802-440-0280

PATIENT INTAKE FORM

PATIENT NAME *(FIRST)* _____ *(MI)* _____ *(LAST)* _____

DATE OF BIRTH ___ ___ / ___ ___ / ___ ___ ___ ___ GENDER M F Other:_____

ADDRESS _____
CITY _____ STATE _____ ZIP _____

PHONE *(HOME)* _____ *(WORK)* _____ *(CELL)* _____
EMAIL ADDRESS: _____
EMPLOYER _____ JOB TITLE _____ *FULL TIME or PART TIME*
STUDENT YES NO *(WHERE)* _____*FULL TIME or PART TIME*

EMERGENCY CONTACT _____ *(PHONE)* _____
(RELATIONSHIP) _____

DIAGNOSIS (IF HAVE ONE): (specific R or L) _____

INJURY / ACCIDENT DATE _____

REFERRING DOCTOR: *(FIRST)* _____*(LAST)* _____
(CITY) _____ *(STATE)* __

PRIMARY CARE PHYSICIAN: *(FIRST)* _____ *(LAST)* _____
(CITY) _____ *(STATE)* _____

HOW DID YOU HEAR ABOUT US? IF A FRIEND, PLEASE TELL US WHO SO WE MAY THANK THEM
_____

PRIMARY INSURANCE INFORMATION:

INSURANCE COMPANY NAME: _____
POLICY #: _____
TYPE OF INSURANCE ____ WORK COMP ____ MEDICAID ____ MEDICARE ____AUTO (MVA) _____ COMMERCIAL

INSURED / POLICY HOLDER NAME *(FIRST)* _____ *(MI)* ____ *(LAST)* _____
RELATIONSHIP ___SELF___SPOUSE ___MOTHER ___FATHER ___OTHER
*(ADDRESS)*_____ *(CITY)* _____ *(STATE)* _____ *(ZIP)* _____
(HOME PHONE) _____ *(WORK)*_____ *(DATE OF BIRTH)* _____
EMPLOYER _____

WORKERS COMP INFORMATION:
INSURANCE COMPANY NAME _____ ADDRESS _____
TELEPHONE # _____ CASE MANAGER NAME _____
CLAIM # _____
PATIENT'S SS # ___ ___ ___ **/** ___ ___ **/** __ __ __ __ DATE OF INJURY:_____
LIGHT DUTY OR FULL DUTY: _____OUT OF WORK SINCE: _____

_____
Office Use Only:

DATE PATIENT CALLED/REFERRAL RECEIVED: _____ INITIAL EVAL DATE: _____

_____ Set Up in WEBPT _____ Mail/Email Reg Packet ____ Insurance Verified (Auth Needed (Y or N)