SPECTRUM PHYSICAL THERAPY

Intake Questionnaire Date____________________ Referred By _________________________

Last Name________________________________ M.I._____ First Name______________________

Address____Sex: M F Marital Status _________

City___________________________________ State_______________Zip_____________________

E mail best to reach you ______________________________

Phone (H)_________-_________-________ (W)_______-_________-_______ (C) ______-________-_________

Date of Birth____________-___________- **19**___________ SS#__________-____________-__________

Referring Doctor's Name and Phone #______________________________, ________-________-________

Body Part to Be Treated _____________________________ * **Surgery Date** ____________________

How Did You Hear About Us? **Doctor** **Friend/Family** **Insurance Company**

Internet **Spectrum Website** **Advertisement**

Other____

INSURANCE INFORMATION

Primary Insurance Company Name:____________________ Insurance ID Number ______________________

Local Union No.(If Magnacare)_______________Insurance Company Phone # ________-_________-_________

Plan Type (HMO, PPO, etc) ___________ Group Number ___________ Effective Date _____-_____-______

Pre-Cert/Referral Required? Y N _____________ Deductible $________ **Co-Payment Amt $** __________

Are you the insured? Y N - **If you are not the policy holder please furnish the following information:**

Policyholders Name_____________________________ Relationship to patient: Spouse Child Parent

DOB_________-_________-_________ SS#__________-__________-__________

Secondary Insurance Company:_____________________________________**ID#**______________________

* Are you currently seeing a **Chiropractor** for this condition? Yes or No

Workman's Compensation/No Fault Information

Date of Injury ------------/----------/------------- Claim #_____________________________________

Employers Name _________________________________ Employers Phone #__________________________

Insurance Co. Name and Address____

Adjusters Name _______________________________ **Phone #** ________- ________-_________ **Ext**______

Fax # __________-__________-__________ **State(If No Fault Accident)** __________

SIGNATURE OF PATIENT X____