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**_____