Intake Done By:
(*Initials & Date*):

Patient Intake/Verification Form
ORTHO/PT
Commercial Insurance

Body Part: ________________
Where did it occur? ________________
Have you had any:
X-Rays? Y N
MRI? Y N
Surgery? Y N
Patient will:
Bring / Fax
Written Report* / Films
Have you been seen elsewhere for this problem? Y N
APPT. DAY AND TIME
____

Patient Name: ______________________________
Home Phone: ____________ Work Phone: ____________
Address: ____________________ City: ________ Zip: ________
DOB: __________ SS#: ______________ (M): ___ (F): ___
Emergency/Guardian: ____________________Relationship________
Home Phone: ______________ Work Phone: ______________
Employer: ______________________ Phone: ____________
Occupation: ______________
Family Doctor's Name: ________________ Phone: __________
*Test Facility Name: ________________ Phone: __________
*Written Reports are necessary, and Films, although not necessary, are helpful.

	PRIMARY	SECONDARY
Insurance Carrier:		
Insurance Phone:		
ID#:		
Group#:		
Insured's Name:		
Insured's DOB/SS#:		
Insured's Address:		
Relation:	Self___ Spouse___ Child___ Other___	Self___ Spouse___ Child___ Other___

I authorize the release of any medical information necessary to process this claim. I assign benefits to the doctor. In addition, I agree to remit any payment received from my insurance carrier(s) for services rendered. In the event that my insurance denies payment for services rendered, I agree that I will be responsible for arranging payment to the doctor.

SIGNATURE:______________________________ DATE:______________

Verification of Primary Insurance *(for Office Use Only)*: Done By (*Initials & Date*): ______________
Effective Date: ______________ Spoke With: ____________________
Dr. Participates ______ Does not participate ______
Is referral needed? Yes ______ No ______ Out-Of-Net Benefits? Yes ______ No ______
Is referral needed for X-rays Yes______ No ______
Co-pay: $_________ X-Ray Co-pay: $_________ Deductible: $_________ Been met? $_________
Claims Address: ________________________ City: ____________ Zip: ________
If Patient needs PT, is Authorization required? Yes / No ____________________
Fax #: ______________ Fax attn to: ____________________________
ELITE Participates ______ Does not participate ______
Can be treated for PT? Yes ______ No ______ Can be treated for PT? Yes ______ No ______
How many visits allowed? ______ per ________ How many visits allowed? _____ per ________
Is referral needed? Yes ______ No ______ Out-Of-Net Benefits? Yes ______ No ______
Co-pay: $___________ Deductible: $_________ Been met? $_________