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

Patient Intake/Verification Form
STUDENT SPORTS INJURIES

Patient Name: _____

Home Phone: _____ Work Phone: _____

Address: _____ City: _____ Zip: _____

DOB: _____ SS#: _____ (M): ___ (F): ___

Parent/Guardian (1): _____

Home Phone: _____ Work Phone: _____

Address: _____ City: _____ Zip: _____

DOB: _____ SS#: _____ (M): ___ (F): ___

Employer Name: _____ Phone: _____

Parent/Guardian (2): _____

Home Phone: _____ Work Phone: _____

Address: _____ City: _____ Zip: _____

DOB: _____ SS#: _____ (M): ___ (F): ___

Employer Name: _____ Phone: _____

How Did Injury Occur? _____

_____

Family Doctor's: _____Phone: _____

_____
Body Part Injured

_____
Where did it occur?

_____
Date of Accident

_____
School

_____
Coach

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? Y N

APPT. Date and Time

_____

	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? $_____