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

Patient Intake/Verification Form
ORTHO/ PT
Worker's Compensation or No Fault

Body Part:
_____
Where did it occur?
_____
Have you had any:
X-Rays? Y N
MRI? Y N
Surgery on this part of the body? Y N
Patient will:
Bring / Fax
Written Report* / Films
Have you been seen elsewhere for this? Y N
If Yes Where?
_____
_____
APPT TIME AND DATE:
_____

Patient Name: _____
Home Phone: _____ Work Phone: _____
Address: _____ City: _____ Zip: _____
DOB: _____ SS#: _____ (M): ___ (F): ___
Emergency Contact: _____Relationship_____
Emergency Home Phone: _____ Work Phone: _____
Employer Name: _____ Phone: _____
Address: _____ City: _____
Date of Accident: _____
How Did Injury Occur? _____
_____
_____
What Body Part Was Injured? _____
Family Doctor's Name: _____ Phone: _____
*Test Facility Name: _____ Phone: _____
* Written reports are necessary, and Films, although not necessary, are helpful.

Circle One: WORKER'S COMPENSATION NO FAULT

Insurance Carrier: _____
Insurance Phone: _____

Worker's Comp-
CC#: _____
WCB#: _____

No Fault-
Policy #: _____
File #: _____

No Fault Patients:
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 Worker's Comp Insurance *(for Office Use Only)*:
Claims Address: _____ City: _____ Zip: _____
Case Manager's Name:_____ Phone:_____ FAX:_____

Verification of No Fault Insurance *(for Office Use Only)*:
Claims Address: _____ City: _____ Zip: _____
Case Manager's Name:_____ Phone:_____ FAX:_____
Is File Open? Yes _____ No _____ $ Left _____