

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: _____

<u>Verification of Primary Insurance (for Office Use Only):</u> 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? \$ _____