ELITE SPORTS MEDICINE & PHYSICAL THERAPY Patient Intake Form

Patient Information			
Last Name:	First Name:	Middle:	DOB:
Address:	City:	State:	Zip:
Home Phone:	Cell:	SSN:	Sex: ☐ Male ☐ Female
Status: ☐ Employed ☐ Student			
Email Address:	Occupation:		

Referral Information		
Referring Physician/Other:	Primary Care:	Diagnosis:

Primary Insurance Carrier/Policy Holder Information		
Primary Insurance:	Insurance Identification Number: Group Number:	
Policy Holder Name:	**Is this a Medicare Replacement Plan?** ☐ **Yes** ☐ **No**	Sex: ☐ Male ☐ Female
Relationship to Patient: ☐ Parent ☐ Spouse ☐ Other	Date of Birth:	Policy Holder Address:
Policy Holder Home Phone:	Employer/Employer Address:	

Secondary Insurance Carrier/Policy Holder Information		
Secondary Insurance:	Insurance Identification Number:	
Policy Holder Name:	Sex: ☐ Male ☐ Female	Relationship to Patient: ☐ Parent ☐ Spouse ☐ Other
Date of Birth:	Policy Holder Address:	Policy Holder Phone:

Additional Questions			
Date of Injury:	**Personal Injury:** ☐ **Yes** ☐ **No**	**Auto Accident:** ☐ **Yes** ☐ **No** **Accident State:** ____	**Work Related:** ☐ **Yes** ☐ **No**

Emergency/Patient Account Contact Information		
Contact Name:	**Phone Number:**	**Relationship to Patient:**

Acknowledgement	
I understand that if any changes are made to my personal or insurance information, it is my responsibility to inform the facility of said changes in a timely manner.	**Patient Signature:** ____________________

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