Elite Sports Medicine & Physical Therapy, LLC Patient Intake Form

PATIENT INFORMATION			
Full Name (First, MI, Last, Suffix):	SSN:		DOB:
Address:	City:	State:	Zip Code:
Home Phone:	Cell:	Sex: Male Female	
Status: ☐ Married ☐ Single ☐ Divorced	Reason for Referral (Diagnosis)		
E-mail Address:	Would you like to receive e-mail appointment reminders? ☐ Yes ☐ No		
How did you hear about us?	Would you like to receive electronic statements? ☐ Yes ☐ No		
Emergency Contact:	Phone:	Relationship:	
Referring Physician:	Primary Care Physician:		
Is this injury related to any of the following (circle one) Work Auto Accident Other N/A			

EMPLOYER INFORMATION		
Employer Name:	Occupation:	Work Phone:
Employer Address:	Work Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐Student	

PRIMARY INSURANCE INFORMATION/POLICY HOLDER INFORMATION		
Primary Insurance:	ID Number:	Group Number:
Policy Holder Name: (if other than self) ☐ Spouse ☐ Parent ☐ Other		Policy Holder DOB:
Policy Holder Address: (only if different)	City/State:	Zip Code:
Policy Holder Phone:	Policy Holder Employer:	

SECONDARY INSURANCE INFORMATION/POLICY HOLDER INFORMATION		
Secondary Insurance:	ID Number:	Group Number:
Policy Holder Name: (if other than self) ☐ Spouse ☐ Parent ☐ Other		Policy Holder DOB:
Policy Holder Address: (only if different)	City/State:	Zip Code:
Policy Holder Phone:	Policy Holder Employer:	

WORKER'S COMPENSATION or AUTO/LIABILITY INFORMATION		
Worker's Comp, Auto Carrier or Attorney Name:	Date of Injury:	Accident State:
Claim Number:	Contact Name & Phone Number:	

By Signing below, I acknowledge that all of the above information is true and accurate. If at any time any of this information changes, I am aware that I must inform the facility immediately.

Patient/Guardian:	**Date:**