FOOTHILLS
Physical Therapy

Patient Intake

Referring Physician if applicable: ____

How did you hear about us?

Friends & Family	Social Media	Internet/Website	Community Outreach	Other

Patient Name (First/Last): ____

Nicknames/Preferred Name: ____

D.O.B: ______________________ Age: _______________ Gender: Male/Female/Other

Last 4 of SSN: _______________ Email Address: _______________________________

Home Address: ___________________________________ City: ___________________

State: _______ Zip Code: __________ Marital Status: Married/Single /Divorced/Widowed

Preferred contact method for appointment reminders: **Text Message Voice Call Email**

Primary Phone: ____________________________ (Home, Work, Cell)

Secondary Phone (If applies): _______________________________ (Home, Work, Cell)

Emergency Contact Name: _____________________ Phone: ____________________

Employer: _______________________________ Occupation: _____________________

*****Are you currently receiving ANY home health related services? Yes/No*****

*****Have you received ANY home health related services this year? Yes/No*****

If yes, discharged date? ___________________ How many Visits: _____________

(Please be aware attending Home Health or another Physical Therapy/Chiropractic office may count towards your insurances visit maximum. You must be discharged from Home Health before the date of your first visit with us.

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Insurance Policy Holder Information:

Policy Holder Name: ____

D.O.B: _________________ Last 4 of SSN: ______________ Gender: Male/Female

Relation to patient: Self   Spouse   Parent   Other

Address: _____________________________City: ________________ State: ______

Zip Code: ____________Primary Phone: ________________________ (Home, Work Cell)

Employer: ____________________________ Occupation: ________________________

Guarantor Information (Person Responsible for the Bill):

****Anyone under the age of 18 must have a guardian/parent on file****

Name (First/Last): ____

D.O.B: _______________________ Last 4 of SSN: ______________ Gender: Male/Female

Address: _____________________________ City: _______________ State: ___________

Zip Code: ______________ Primary Phone: ______________________ (Home, Work, Cell)