WESTLAKE PHYSICAL THERAPY

We appreciate the opportunity of serving you. We pledge to give you our very best medical care.

PATIENT INTAKE FORM

Patient's Full Name ________________________________ Sex: ☐M ☐F Birthday:____/_____/_____

Address____________________________________ City __________________ ST_____ Zip _________

Mailing Address______________________________ City _________________ ST______ Zip _________

H. Phone__________________________ [ ] Primary Secure to Leave Detailed Voicemail? ☐ Yes ☐ No

Cell Phone_________________________ [ ] Primary Secure to Leave Detailed Voicemail? ☐ Yes ☐ No

Identification: SSN___________________________ or provide Drivers License for PHOTO ID scan

Email Address: ____

(Used for electronic statements, survey & newsletter)

Responsible Party: Name ______________________________________ Relation________________

Phone Number ____________________________ Parent/Guardian SSN ______________________

Emergency Contact: Name ___________________________ Relation_____________ Phone_____________

How did you hear about us?

☐ Physician ☐ Insurance ☐ Internet ☐ Former Patient:_________________ ☐ Other:_____________

SYMPTOM INFORMATION

Body Part_________________________

Symptom First Noticed _____/_____/_____ Work related? ☐Yes ☐No Auto Accident? ☐Yes ☐No

Did you need surgery? ☐Yes ☐No Date of Surgery_____/______/_______

Doctors Name_____________________ Last Seen _____/_____/_____ Follow Up Visit _____/_____/_____

INSURANCE INFORMATION

Please Fill Out Information Below and Give Your Card to the Front Desk

Primary____________________________________

ID # ____________________________________

Subscriber's Name ___________________________

Birthday _____/______/__________

Relationship _______________________________

Secondary ______________________________

ID # ____________________________________

Subscriber's Name ___________________________

Birthday _____/______/__________

Relationship _______________________________

CONSENT FOR TREATMENT

I hereby authorize Westlake Physical Therapy to administer diagnostic and medical procedures which may include but is not limited to: therapeutic exercises, manual therapies, and modalities as may be necessary for proper healthcare. This agreement is in effect until I choose to revoke it in writing.

__________________________________ ________________ ________________

Signature of Patient or Responsible Party Date Relationship