ROBA
PHYSICAL THERAPY
AND WELLNESS

PATIENT DEMOGRAPHICS
INTAKE FORM

GENERAL INFORMATION

Name - First: _____ Last: _____ Gender: _____

Date of Birth:_____ Phone: _____ Home Phone: _____

Email:_____

Primary Care Physician:_____ Phone Number: _____

Occupation:_____

Have you had PT in the last 12 months? No Yes - Approximately how many visits _____

How did you hear about this clinic?_____

HEALTH INSURANCE INFORMATION

Please be sure you are familiar with your health plan's benefits for PT. (i.e. co-pay, deducible, number of visits allowed, authorization/referral requirements)

Insurance Type:_____

Member ID/Policy #:_____ Subscriber's Name:_____

Relationship:_____ Subscriber's Date of Birth:_____

Secondary Insurance (Type & ID) #:_____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name:_____

Relationship:_____

Home Phone #:_____ Cell Phone #:_____