ROBA
PHYSICAL THERAPY
AND WELLNESS

PATIENT DEMOGRAPHICS
INTAKE FORM

Please complete the following forms and return to the office with a copy of your identification (state ID or Driver's license) along with your insurance card (front and back) Email: frontdesk@robaphysicaltherapy.com or Fax: 860-422-4632

GENERAL INFORMATION

First Name: _____ Last Name: _____ Gender:_____

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

Address:_____

Email:_____

Occupation:_____

How did you hear about this clinic?_____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name:_____

Relationship:_____

Home Phone #:_____ Cell Phone #:_____

HEALTH INSURANCE INFORMATION (REQUIRED)

Health Insurance:___ Self Pay:___ Personal Training:___ Work/Auto Accident:___

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

Primary Insurance Company:_____

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

Relationship:_____ Subscriber's Date of Birth:_____

Secondary Insurance Company:_____

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

Relationship:_____ Subscriber's Date of Birth:_____