Patient Information Intake Form

Date: ____________

Name: ____ DOB: ________________

Address: ______________________________________ SS#: ________________

City: ______________________________ State: __________ Zip: ________________

Home phone: ____________ Work phone: _____________ Mobile phone: _____________

Employer: ___________________________ Your email: ___________________________

Emergency contact: ________________ Relationship: __________ Their phone#: __________

Referring Physician: ___________________________ Phone: ____________________

Primary Physician: ____________________________ Phone: ____________________

Name of Insurance to bill: ____

Address: ______________________ City: __________ State: _________ Zip: ______

ID/ Policy/ Claim #: __________________ Group #: _____________

Health Insurance Subscriber: (circle) self spouse parent

If Workers comp or auto accident- Date of injury: _____________ If Auto, state of accident: ________

WC: Adjuster: ________________ phone#: ______________

Privacy/ HIPAA Notice, Release of information and Consent to treat

Granite State Physical therapy feels that your privacy is of most importance and should be protected. While in treatment here at GSPT, we collect personal information that is needed for your treatment. We are required by law to protect that information and disclose it only to those that need to know such as your physician(s), insurance company and case managers. A copy of our complete HIPAA policy is available upon request. By signing below, I acknowledge that I have been permitted to access and/or upon request, have been provided a copy of this policy.

I hereby authorize release of my medical information pertinent to my current care and consent to treatment procedures and patient care which, in the judgment of my therapist and/ or physician is necessary. I understand treatment may produce increased pain, soreness and /or swelling at times but that I will discuss this with my treating therapist.

Signature: ____________________________ Date: ________________