



Head to Toe

PHYSICAL THERAPY

Personal Insurance Intake Form

Patient Information:

Name _____

Address _____

Occupation _____

Employer _____

Address _____

If minor, name of parent or guardian _____

How did you hear about Head to Toe Physical Therapy? _____

Primary Care Physician _____

Name of contact in case of emergency _____

Relationship _____

Home Phone _____

Work Phone _____

Cell Phone _____

Email _____

Social Security No _____

Date of Birth _____ Age _____

Sex Male Female

Referring physician _____

Phone _____

Insurance Information:

If you have worker's comp/auto insurance please fill out section (2), If not please fill out section (1) only.

(1) Primary Insurance Company _____

Identification # _____

Policy Holder _____ Relationship _____

Copay/coinsurance _____ Deductible _____ Met? Yes No

(2) Worker's Comp/Auto Insurance Name _____

Insurance Address: _____

Insurance Phone Number: _____ Adjuster: _____

Employer's Name: _____

Employer's Address: _____

Claim Number: _____ Badge Number: _____

Dept. Number _____

Date of Injury: _____

Attorney's Name & Address: _____

Attorney's Phone _____