

# *Atlantis Physical Therapy Group, Inc.*

*Personalized Fitness Solutions to Enhance People's Lives*

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## Health Insurance Intake Form

Intake Date: \_\_\_\_\_ Interviewer: \_\_\_\_\_

### BASIC PATIENT INFORMATION

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ **M / F**

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone/Pager: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security No: \_\_\_\_\_ License: \_\_\_\_\_

Marital Status:      **Single**      **Married**      **Divorce**

### EMPLOYMENT INFORMATION

Employer Name: \_\_\_\_\_

Occupation: \_\_\_\_\_ Tele #: \_\_\_\_\_

Are you missing time from work? **YES**    **NO**    (circle one)

How long? \_\_\_\_\_

### HEALTH INSURANCE INFORMATION

Do you have Health Insurance?    **YES**    **NO**    (circle one)

Name of Health Insurance Carrier: \_\_\_\_\_

Address: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Card No: \_\_\_\_\_

Group No: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

What are your major complaints: \_\_\_\_\_

\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone No: \_\_\_\_\_

Referral obtained: YES NO

How many visits were approved: \_\_\_\_\_

\_\_\_\_\_

<b>DESCRIPTION OF INJURY/ COMPLAINTS</b>
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Brief description of injury/complaints please write below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand and agree that Health and Accident Insurance policies are an arrangement between the insurance carrier and myself. I authorize payment from my Insurance Carrier directly to this office with the understanding that all monies will be credited to my account upon receipt.

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patients Signature: \_\_\_\_\_