JAMAICA PHYSICAL THERAPY P.C.
"Where Quality And Effective Treatment Count"℠

Patient Intake Form

Patient Information

First Name: _____ Middle Initial: ___ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone # :(_____) _____Cell Phone #: (____)_____Carrier:_____

Birthdate: __/__/___ Social Security Number (SSN):_____

Email Address:_____Gender: _____ Height: _____ Weight: _____

Employment Status: (Circle One) Employed F/T orP/T, Student, Retired, Unemployed

Occupation: _____ Employer: _____

Work Address: _____

City: _____ State: _____ Zip Code: _____ Phone # :(___) _____

Marital Status: (Circle One) Single, Married, Divorced, Widowed

Spouse Information:

Name: _____ SSN: _____ Phone # :(____) _____

Occupation: _____ Employer: _____

Work Phone # :(____) _____

Emergency Contact

Name: _____ Relation: _____ Phone # :(____) _____

Referring Physician:

First Name_____ MI _____ Last Name_____ Phone # :(____) _____

Address: _____ City: _____ State: _____ Zip: _____

Patient Referral Information

How did you hear about us? _____

Workers' Compensation or Auto Accident/ No Fault

Injury Date: ___/___/___ Place of Injury: _____

Description of Injury: _____

Prior Similar Injury ☐ Yes ☐ No

If Yes, Explain: _____

Unable to work from: ____/_____/_____ To: _____/_____/_____

Driver's License Number: _____

Attorney Name: _____

Attorney Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance

Insurance Plan Name: _____ Insurance ID #: _____ Group #: _____

Relationship to Insured: Self ☐ Dependent ☐ Spouse ☐ Other ☐ Explain:_____

If other than Self:

Insured's Name:_____SSN:_____ Date of Birth:___/____/____ Gender:___

Address:_____ City:_____ State:_____ Zip:_____

Employer:_____ Work Phone #:_____

Secondary Insurance

Insurance Plan Name: _____ Insurance ID #: _____ Group #: _____

Relationship to Insured: Self ☐ Dependent ☐ Spouse ☐ Other ☐ Explain:_____

If other than Self:

Insured's Name:_____ SSN:_____ Date of Birth:___/____/____ Gender:___

Address:_____ City:_____ State:_____ Zip:_____

Employer: _____ Work Phone #:_____

Tertiary Insurance

Insurance Plan Name: _____ Insurance ID #: _____ Group #: _____

Relationship to Insured: Self ☐ Dependent ☐ Spouse ☐ Other ☐ Explain:_____

If other than Self:

Insured's Name:_____ SSN:_____ Date of Birth:___/____/____ Gender:___

Address:_____ City:_____ State:_____ Zip:_____

Employer: _____ Work Phone #:_____

_____ _____/____/_____

Signature of Patient or Representative **Date**