Optimum Care Physical Therapy, LLC
Where care matters

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Email: contact@theoptimumcare.com
Website: www.theoptimumcare.com

Patient Intake Form

Name: _____ Date: _____

Address: _____
street city state zip

Sex: Male/Female Date of Birth: _____ SS#:_____

Emergency Contact: _____Phone: _____
Relationship: _____

Referring Physician_____Phone:_____

Employment Information
Employed F/T_____ Employed P/T_____ Student F/T_____ Student P/T_____
Not Employed_____ Self Employed_____ Retired_____ Active Military_____

Employer/School: _____
_____
Address:_____
street city state zip

Insurance Information
Insurance Company: _____Insured's Name:_____

Insurance Policy Number:_____Insured's Date of Birth:_____

Insurance Group Number: _____Insurance Phone:_____

Date of injury or onset of symptoms: _____

Are you seeking treatment as a result of a work related injury? Yes No
Are you seeking treatment as a result of a car accident? Yes No
Are you involved in a lawsuit because of your injury or symptoms? Yes No

I authorize and request the above named insurance company to pay benefits for services rendered. I authorize Optimum Care Physical Therapy to use, disclose, and release all medical information necessary to process my health insurance claims.

_____ _____
Patient Signature Date