Montrose Road Suite 350
Potomac, MD 20854
(301)417-8283

PATIENT INTAKE FORM

Name:			Social Security #	
Date of Birth:	Age:	Sex:	Male____	Female ____
Address:	City:	State:	Zip Code:	
Home Phone:	Cell Phone:		Email:	
Emergency Contact:	Relationship:		Phone #:	
Occupation:	Employer:			
Marital Status:	How Did You Hear About Us:			

PHYSICIAN INFORMATION

Referring Physician:	Phone Number:
Primary Care Physician:	Phone Number:

INSURANCE INFORMATION

Insurance Company:	Relationship to Insured:	Self	Spouse	Other:
Policy Number:	Group Number:			

AUTO INJURY OR WORKMAN'S COMPENSATION

Date of Injury:	Claim Number:
Name of Insurance Company:	Phone Number:
Name of Adjuster/Case Manager:	Phone Number:
Name of Attorney:	Phone Number:

Payment Agreement: I hereby authorize Adept Physical Therapy, LLC to furnish information to the insurance carriers concerning my treatment and hereby assign to the therapist(s) all payments for services rendered. If for any reason my claim is denied and payment for physical therapy is stopped, I agree to pay in full any charges that are outstanding to Adept Physical Therapy, LLC.

Signature____ Date__________________________