Rancho Del Mar
PHYSICAL THERAPY

New Patient Intake Form

Appointment Date_____Time_____

PATIENT INFORMATION

Name_____Sex_____

Last First

Address_____

_____

City State Zip

Date of Birth_____Social Security #_____
Home Phone_____Work Phone_____
Mobile Phone_____
Email_____

Marital Status: Single ☐ Divorced ☐ Married ☐ Separated ☐ Widowed ☐ Unknown ☐

Employer_____ Emp Phone #_____
Address_____
Occupation_____Status: Full Time ☐ Part Time ☐
Emergency Contact_____ Phone #_____
Relationship_____

Referring Physician_____Office Phone #_____
Address_____

Injury Type: Work ☐ Auto ☐ Home ☐ Other _____ Lawyer Involved? Yes ☐ No ☐
Attorney Name_____Phone #_____
Address_____
Injured Area(s)_____Date of Injury _____

INSURANCE INFORMATION

Primary Insurance_____

Insured's Name_____D.O.B_____

Secondary Insurance_____
Insured's Name_____D.O.B_____

Signature of Patient_____Date_____

RESPONSIBLE PARTY INFORMATION (if other than patient)

Responsible Party_____
Last First
Relationship of Patient to Responsible Party_____
Address_____

_____

City State Zip

Employer_____ Emp Phone #_____
Address_____
Home Phone_____Work Phone_____
Mobile Phone_____ Email_____
Date of Birth_____Social Security #_____

Signature of Responsible Party_____Date_____