Patient Intake Form for Laguna Orthopedic Rehabilitation

Personal Information

Last Name:	First Name:	MI:
Address:		
City:	State:	Zip Code:
Home Phone:	Cell Phone:	
Social Security#:	Date of Birth:	Age:
Sex: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Other	
Referred By:	Driver's License #:	
Email Address:		
Yes, I would like to receive appointment notifications by: ☐ email ☐ none		

HIPPA Information

☐ I agree to allow Laguna Orthopedic Rehabilitation/Grace Physical Therapy to release my information for claims processing
☐ I agree to accept assignment of payment
☐ I give Laguna Orthopedic Rehabilitation/Grace Physical Therapy permission to leave a message on my answering machine

Emergency Contact Information

Last Name:	First Name:	
Address:	State:	Zip Code:
Phone Number:	Relationship to Patient:	

Other Information

Were you in an automobile accident? ☐ Yes ☐ No	Date of accident:

Patient Certification and Signature

I certify that all of the information provided above is true and correct. I authorize the the clinic and its affiliates to release information to my insurance company if required to expedite payment. I authorize payment directly to Grace Physical Therapy, Inc. and understand that my insurance company is being billed as a courtesy to me. I also understand that my benefits are being verified but are not a guarantee of coverage. If the information provided by my insurance company is not accurate or the coverage changes, I will be responsible for payment on all services not paid. If needed I authorize Grace Physical Therapy, Inc. to release my information to the Centers for Medicare and/or Medicaid Services and its agent to determine the benefits payable for my related services. I also acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures.

Patient/Guardian Signature: _____ Date: _____

For Office Use Only

Prescription Information

Referring M.D.:	Date of RX:	Date of Evaluation:
Physical Therapists Name:	DX:	

Insurance Information

Primary Insurance:	Secondary Insurance:
Claims Address:	Claims Address:
ID #:	ID #:
Group #:	Group #:

Workman's Compensation Information

Insurance Company Name:	Claim #:
Claims Address:	Adjuster Name:
	Adjuster Phone #:
Date of Injury:	Authorization #: