Dignity Health
Physical Therapy
in partnership with Select Medical

☐New Patient ☐Previous Patient
☐PT ☐OT ☐SLP ☐ABA

Patient Information Form

Patient Demographic Information				
***Last Name**	***First Name**		***Middle Initial**	
Address	Apt/Bldg/Ste#	City	State	Zip Code
***Home Phone**	***Appointment Reminder Contact Method** (Choose method of choice) ☐Text ☐Mobile ☐Email ☐Home Phone ☐No Appointment Reminder			
***Mobile Phone**	***Email Address** ☐Declined Email ☐No Email			
***Date of Birth**	SSN	***Sex** ☐F ☐M	Status ☐Single ☐Married ☐Other	

Employer Information				
Employer	Employment Status ☐FT ☐PT ☐None ☐Retired ☐Student			
Address	City	State	Zip Code	
Work Phone	Occupation			

Emergency Contact Information		
Contact Name	Phone	Relationship

Physician Information		
***Referring Physician**	Phone	Script Date

Additional Questions			
Injury /Onset Date	Post-Surgical ☐Yes ☐No	Surgery Date	***Body Part**
Work Related ☐Yes ☐No	Accident Related ☐Yes ☐No	Auto Related ☐Yes ☐No	Attorney Involved ☐Yes ☐No
Adjuster/Nurse Cases Mgr.	Phone	Attorney	Phone
Have you had prior therapy this year? (PT/OT/SP/Chiro) ☐Yes ☐No		How did you hear about us?	

Medicare ONLY! Additional Questions	
If Medicare, are you currently receiving home health services? ☐Yes ☐No	
If yes, name of agency:	If discharged what is last date of service?
Are you currently residing in a skilled nursing facility? If yes, name of facility:	

Primary Insurance Plan Information		**Secondary Insurance Plan Information**	
***Insurance/Plan**		***Insurance/Plan**	
***Policy ID #**		***Policy ID #**	
***Group #**		***Group #**	
***Insurance Phone**		***Insurance Phone**	
***Are you the policy holder?** ☐Yes ☐No If no, continue		***Are you the policy holder?** ☐Yes ☐No If no, continue	
***Policy Holder Name**	***DOB**	***Policy Holder Name**	***DOB**
***Patient relationship to policy holder:** ☐Self ☐Spouse ☐Child		***Patient relationship to policy holder:** ☐Self ☐Spouse ☐Child	
Patient, please initial here if the above information is correct and complete		Date	

Office staff use ONLY (below) - **For digital intake, only the fields highlighted/italicized are required*		
Intake completed by	Date	***Date Eval Scheduled**
Registered by	Date	Acct #
Patient Service Specialist will initial next to each task below once completed.		
Billing Disclosure added in Comments☐	Verified DL/Photo ID☐	Consent to receive calls and/or text messages, reviewed with patient. If patient agrees and signed consent, is text enabled box checked in TS?☐

Last updated 1/20/2021