



Please review with each patient:

- ☐ Bring Rx & Insurance Card(s)
- ☐ Request they arrive 15 min. early for paperwork
- ☐ Wear clothing appropriate for exercise
- ☐ Confirm they know where we are located, date & time of appt. and who they will be seeing.

**DATE:** \_\_\_\_\_ **Intake Completed by:** \_\_\_\_\_

## Patient Information Form

Patient's First Name:		MI:		Last Name:	
Street Address:					Apt#:
City:	State:	Zip:	Birthdate:	Dx:	Sex M/F
Home Phone:	Business Phone	Emergency Contact:		Emergency Contact Phone:	

### Referral Information:

Treating Physician/Referring Specialist:		Facility Name/Address:	
Date seen by physician:		Phone:	Fax:
Primary Physician/Family Doctor		Facility Name/Address:	
		Phone:	Fax:
How did you hear about us? (FitLife Member, friend, former patient, doctor, ad, internet, drive/by, yellow pages, at work, etc.):			

### Insurance Information:

Medicare:	Medicare#:	Effective Date:	Circle: Part A                      Part B	
Worker's Comp. or Auto Accident:	Name of Insurance:		Address of Insurance:	
	Claim#	Date of Injury:	Adjuster:	Phone#:
	Case in Litigation: Yes/No	Attorney Name:		Attorney Phone Number:
Other Insurances:	Insurance Carrier Name:			
	Insurance Carrier Address:			Ins. Carrier Phone:
	Subscriber Name:	Relationship:	SS# & DOB of Parent/Spouse if not 1 <sup>o</sup> policy holder:	
	ID#:	Group#:	Ref/Auth#:	

Office Use Only	Diagnoses:	PT:	Date:
-----------------	------------	-----	-------