BodyWise Physical Therapy - Fitness
1667 Lucerne Drive Suite B
Minden, NV 89423
Phone: 775 - 783 - 7606
Fax: 775 - 783 - 7605
www.BWisePT.com

PATIENT INTAKE FORM

Patient Information

Name (First, Initial, Last): ____________________

Mailing Address: ____________________

Physical Address: ____________________

Phone: __________ **Alternate:** __________ **Email:** __________

Social Security# ________--________--________ **DOB** ______ **Gender** ______

Responsible Party (If Minor, Spouse, Power of Attorney, etc)

Name: ____________________

Relationship: ____________________

Address: ____________________

Phone: __________ **Alternate:** __________ **Work:** __________

Social Security# ________--________--________ **DOB** __________

Email: ____________________

Employer Info

Employer: __________ **Job Title:** __________ **Phone:** __________

Insurance Information (list what your ID card does NOT show)

Primary Insurance: __________ **Primary Insured:** __________

Insurance Address: ____________________

Phone: __________ **Fax:** __________ **Website:** __________

Policy/ID# __________ **Group#** __________

Secondary Insurance: __________ **Primary Insured:** __________

Insurance Address: ____________________

Phone: __________ **Fax:** __________ **Website:** __________

Policy/ID# __________ **Group#** __________

Workers Compensation Info:

Carrier: __________ **Adjuster/Phone/Fax:** __________

Claim# __________ **Address:** __________

We do not bill third party payers after accidents, please list name of attorney if applicable:

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I, ____________________ , hereby authorize the release of any information relating to all claims for insurance benefits submitted on behalf of dependents or myself. I further authorize the release of records pertaining to dependents or myself to other physicians, attorneys, or ancillary services (including but not limited to: prosthetic / orthotic / assistive device services, therapies or home health). I give permission to contact me at my address, by telephone, or by e-mail given in medical records.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL SERVICES RENDERED AND RECEIVED.
A penalty may incur for late payments or failing to attend scheduled appointments.

____________________ ____________________

Signature of Patient or Responsible Party Date