SKYLINE HOSPITAL

Physical Therapy & Sports Medicine Intake Form

Patients are responsible for knowing their insurance benefits.

Have you had physical therapy this year? ❑ Yes ❑ No	If yes, list how many visits:		
Date you return to your physician:	Employer:		
Patient name:	Age & date of birth:		❑ Male ❑ Female
Mailing address:	City:	Zip code:	
Physical address:	City:	Zip code:	
Home phone:	Cell phone:		
Social Security number:	Email:		
Marital status:	Spouse's name & date of birth:		
Emergency contact name & relation to patient:	Emergency contact phone:		

For Patients with Medicare

Date of retirement or disability:	Date of spouse's retirement, if applicable:

For Worker's Compensation or Motor Vehicle Accident Claims

Patient's condition related to: ❑ Employment ❑ Auto ❑ Other:		
Have you had physical therapy for this injury? ❑ Yes ❑ No		If yes, list number of visits:
Name of insurance company:		
Date of injury:	Claim number:	State where accident occurred:
Name of claims adjuster:	Phone:	Fax:
Employer at time of injury:		Employer's phone:
Employer's address:		