Apex Physical Therapy
New Patient Intake Form

Date _____

Name (First) _____ (Last) _____ (M.I.) _____

Home Address _____City_____ Zip_____

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security _____ Birthdate _____ Age _____ Sex: M / F

Email Address _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐Separated ☐ Widowed

Emergency Contact _____ Telephone _____

Referring Doctor _____Telephone_____

Who may we thank for your referral other than your Doctor? _____

Employment Status ☐ Full-time ☐ Part-time ☐ Not Working ☐ Retired ☐ Student

Employer _____ Address _____ Telephone _____

Injury Type ☐ Work ☐ Auto ☐ Home ☐ Other _____ Injury Date _____

Attorney Involved? ☐ No ☐ Yes If yes, list attorney name _____

Address _____ Telephone _____

Insurance Patients Only

Primary Insurance _____

Claims address_____ Telephone _____

Insured's Name _____ Birthdate_____

ID # _____ Group # _____

Secondary Insurance _____

Claims address _____ Telephone _____

Insured's Name _____ Birthdate _____

ID # _____ Group # _____

Please note that you are financially responsible for any charges not covered by your insurance plan. I request 24 hours notice in order to cancel your appointment without a charge.

Patient Signature _____ Date _____