RECLAIM
PHYSICAL THERAPY

New Patient Intake Form

Patient/ Case Information

Name *(First, MI, Last)*:	**DOB:**	**SSN:**

Home Street Address:	**City:**	**State:**	**Zip:**

Apt #	**Home phone:**	**Cell phone:**	**Gender:** Male ○ Female ○

Reason for Referral:	**Onset date:**

How did you hear about us?:

Primary Insurance Information

Company:	**ID#** **HSA:** Y ○ N ○	**Group#:**

Subscriber:	**Subscriber DOB:**	**Subscriber relation:**

Secondary Insurance Information (if applicable)

Company:	**ID#** **HSA:** Y ○ N ○	**Group#:**

Subscriber:	**Subscriber DOB:**	**Subscriber relation:**

Tertiary Insurance Information (if applicable)

Company:	**ID#** **HSA:** Y ○ N ○	**Group#:**

Subscriber:	**Subscriber DOB:**	**Subscriber relation:**

*** **A copy of each insurance card is required for completion of this form** ***