PORTERA

PATIENT INTAKE FORM

Today's Date: _____ **Appointment Date:** _____ **Time:** _____ **AM/PM**

Previous Patient: Y/N

Patient Name: **(Last, First, Middle)** _____ DOB: ____/____/____

Social Security: ____/____/____ Sex: **M / F** Status: **M_/_S_/_D_/_W_**

Home Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Employer's Name: _____

Emergency Contact: _____ Phone Number: _____

Relationship to Patient: Spouse_/_Parent_/_Sibling_/_Other

Insurance information

Type of Plan: **WC / HMO/ PPO / MEDICARE/ MEDICAID / AUTO**

Primary Insurance: _____ Pol #_____ Grp #: _____

Subscriber's Name: _____ DOB: ____/____/___ SSN: _____

Eff Date: ____/____/____ Copay/Coinsurance: _____ Ded: _____ Met? Y/N Amount Met: _____

Max Visits :_____(Per condition/ Per cal yr.) **PCP Ref Needed**: Y/N **Auth-Cert Needed**: Y/N

Auth/Pre-Cert#:_____#Visits:_____Claim Address: _____

Rep. Name: _____ Confirmation Number: _____

Ins Main Number: _____ Auth Phone: _____Ext: _____

Secondary Insurance: _____Pol #: _____ Grp #: _____

Subscriber's Name: _____DOB: ____/____/____ SSN: _____

Eff Date: ____/____/____ Copay/Coinsurance: _____ Ded: _____ Met? Y/N Amount Met: _____

Max Visits :_____(Per condition/ Per Cal yr.) **PCP Ref Needed**: Y/N **Auth-Cert Needed**: Y/N

Auth/Per-Cert#:_____ # Visits _____Claim Address:_____

Rep. Name: _____Confirmation Number: _____

Insurance Main Number: _____ Authorization Phone: _____Ext: _____

Additional Information

Date of Onset/ Injury: ___/___/____ **Body Part:** _____ **Auto Related**: Y/N (if so) What State: ____

Work Related: Y/N **Surgery**: Y/N **Adjuster's Name**: _____ **Phone**: _____

Attorney Name: _____ **Phone**: _____

Referring Physician Name: _____

Office Number: _____ **Fax Number**: _____