Cornerstone Physical Therapy
5300 Westview Drive, Ste. 108 Frederick, MD 21703

Patient Intake Form

Patient Information

Name: _____ Date of Birth: _____
Address: _____ Age: _____
_____ Home #: _____
Please circle: Male Female Work #: _____
Please circle: Married Single Divorced Widow Widower Cell #: _____
Social Security Number: _____
E-mail address: _____ (we will not share your e-mail address)

Please circle: Work full-time Work part-time Student Retired Disabled Other: _____
Employer: _____
Address:_____
_____
Occupation: _____

Primary Care Physician Information

Name of your Primary Care Physician: _____
Address: _____
_____
Phone Number: _____

Who referred you to our office: _____

Emergency Contact Information

Name of Emergency Contact: _____ Relationship: _____
Phone Number: _____

Visit Information

What is the reason for today's visit: _____
Is this a result from an accident? _____ If yes, please explain: _____
_____
Date you first noticed symptoms or injury date: _____

Insurance Information

Primary Insurance Carrier Name: _____
Claims Mailing Address: _____
_____
Phone Number for Provider Services: _____
Member Identification Number: _____
Group Number: _____
Are you the policy holder for this plan: YES NO
If no, policy holder's name: _____
Date of Birth: _____ Relationship to patient: _____
Policy Holder's Phone Number _____

Secondary Insurance Carrier Name: _____
Claims Mailing Address: _____
_____
Phone Number for Provider Services: _____
Member Identification Number: _____
Group Number: _____
Are you the policy holder for this plan: YES NO
If no, policy holder's name: _____
Date of Birth: _____ Relationship to patient: _____
Policy Holder's Phone Number: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Cornerstone Physical Therapy. I understand that I am financially responsible for any balance. I also authorize Cornerstone Physical Therapy or the insurance company to release any information in processing my claims:

_____
Patient/Guardian Signature

_____
Date