PATIENT INTAKE FORM

TEL: (631) 596-5096
FAX: (631) 594-5370
www.greinerpt.com

"Get Better Faster from the Comfort of Home"
Serving Eastern Long Island

PATIENT INFORMATION

Name		DOB		Sex	Male O Female O		
Address		City		State		Zip	
Phone		Mobile:		Work			
Email		Emergency Contact					

MEDICAL INFORMATION

Reason for Services			
Referring Physician		Phone	
Primary Care Physician		Phone	
Diagnosis			
Patient Goals			
Significant Medical History			

REFERRAL INFORMATION - HOW WERE YOU REFERRED TO GREINER PHYSICAL THERAPY

O Physician Referral		O Internet Search	
O Friend/Family Referral		O Other	
O Greiner PT Website		O Advertisement	

PRIOR TREATMENT

Have you received physical/speech/or occupational therapy with us or another clinic this calendar year?	O Yes O No		
If Yes - What was the reason for treatment?			
Have you received any IN HOME health nursing, physical, occupational, or speech therapy visits in the last 30 days?	O Yes O No		
If Yes - What was the last treatment date?		Last In Home Provider Name?	
Last In Home Provider Phone Number			
Have you been discharged from this treatment?	O Yes O No	DIscharge Date?	

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Move For Life

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PAYMENT/INSURANCE INFORMATION

Medicare Part B	O Yes O No	Medicare Advantage Plan	O Yes O No	Private Pay	O Yes O No
Primary Insurance		Secondary Insurance			
ID#		ID#			
Group#		Group#			
Phone#		Phone#			
Relationship to Patient	O Self O Spouse O Parent	Relationship to Patient	O Self O Spouse O Parent		

RESPONSIBLE PARTY (OTHER THAN PARENT)

Is any other person financially responsible for patient services?	O Yes O No	Responsible Party Name			
If so please list contact details below for invoicing		Relationship to Patient	O Self O Spouse O Parent O Child O Other		
Address		City		State	Zip
Phone		Cell			
Other Information					