

Marcotte Physical Therapy – INTAKE FORM

501 Great Road, Suite 108

North Smithfield, RI 02896

DATE _____ APPT DATE _____ THERAPIST _____ TIME _____

NAME _____ DATE OF BIRTH _____

PHONE: HOME _____ CELL _____ WORK _____

ADDRESS _____

REFERRING DR _____ PHONE _____ DIAGNOSIS _____

PRIMARY CARE DR _____ PHONE _____

PRIMARY INSURANCE _____ PHONE _____

DATE VERIFIED _____ WITH _____ EFFECTIVE DATE _____

MAIL CLAIMS ADDRESS _____

SUBSCRIBER _____ SUBSCRIBER DOB _____

ID# _____ GROUP _____ VISITS ALLOWED _____ USED _____

AUTH _____ REFERRAL _____ SCRIPT _____ AUTH/REFERRAL # _____

DED _____ MET _____ OOP _____ MET _____ CO-PAY _____ CO INS _____

SECONDARY INSURANCE _____ PHONE _____

DATE VERIFIED _____ WITH _____ EFFECTIVE DATE _____

MAIL CLAIMS ADDRESS _____

SUBSCRIBER _____ SUBSCRIBER DOB _____

ID# _____ GROUP _____ VISITS ALLOWED _____ USED _____

AUTH _____ REFERRAL _____ SCRIPT _____ AUTH/REFERRAL # _____

DED _____ MET _____ OOP _____ MET _____ CO-PAY _____ CO INS _____

WORKERS COMP/MVA INFORMATION

INSURANCE COMPANY/ATTY _____ PHONE _____

MAIL CLAIMS TO _____

EMPLOYER _____ PHONE _____

EMPLOYER ADDRESS _____

CLAIM # _____ AUTH# _____ DATE OF INJURY _____

CONTACT/ADJUSTER _____ PHONE _____ FAX _____

UR DEPARTMENT _____ PHONE _____ FAX _____

PATIENT SIGNATURE _____ DATE _____