Visions At Home Physical Therapy
105 Northgate Rd., Suite E • Natchez, MS 39120
Phone: 601 - 568 – 1313 • Fax: 601 – 653 – 9261
Website: visionsathomept.com

# New Patient Intake Form

Patient Name: _____ DOB: _____/_____/_____

Marital Status: Married___ Single___ Divorced___ Widowed___

With whom do you live? Alone___ Spouse___ Children___ Caregiver___ Parent(s)___ Other_____

Patient Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____-_____ Alt Phone: (_____)_____-_____

Email Address: _____ Social Security Number: _____

Emergency Contact/Phone : _____(___)___-____Relationship: _____

Do you have a prescription for physical therapy? Y___ N___

Referring Doctor's Name: _____ Date of Referral: _____

Address: _____

Phone: _____ Fax: _____

Diagnosis: _____

Primary Care Physician (If different than referring Doctor): _____

Employment Status: Full Time___ Part Time___ Unemployed___ Retired___

Employer: _____Phone:_____

Address: _____

City: _____ State:_____ Zip Code: _____

<u>For Medicare Patients Only:</u>

Are you currently receiving home care services? Yes___ No___

If yes, expected date of completion?_____. Do you have a home care discharge letter? Yes___ No___

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# New Patient Intake Form

Do you have Health Insurance: Yes___ No___ Are you the policy holder: Yes___ No___

If no, who is the policy holder: Parent___ Guardian___ Spouse___ Other_____

Policy Holder Name:_____DOB:_____/_____/_____

Home Address:_____

City:_____State:_____Zip:_____

Home Phone:(_____)_____-_____Alt Phone:(_____)_____-_____

Email Address:_____Social Security Number:_____

MEDICARE ID #:_____

Primary Insurance:_____Claim #:_____

ID#:_____GROUP #:_____

Deductible:_____Max Annual Benefit:_____

Copay:_____Coinsurance:_____

Phone:_____

Secondary Insurance:_____Claim #:_____

ID#:_____GROUP #:_____

Deductible:_____Max Annual Benefit:_____

Copay:_____Coinsurance:_____

Phone:_____