Date_____/_____/_____

3DPT Intake Form for New Patients

3DPT initials_____ Date/time of appointment _____
Did they request a specific therapist, if so who?_____

Patient name_____ Date of Birth _____
Address _____ City _____ State_____ Zip _____
Best number to reach you_____ Is this home or cell?
Can we leave a personal message about insurance and your care on this number? _____Yes _____ No
Email address _____
Name of parent/guardian if patient is a minor_____ relationship _____

Do you have an updated script within the past 30 days? _____Yes _____ No
Name of physician _____
Primary care physician _____
What type of injury? _____

How did you hear about 3DPT? _____

Is this injury related to a motor vehicle accident? _____ Yes _____ No
Is this injury related to a work related accident? _____Yes _____ No
Is this injury related to a school accident? _____Yes _____No

Primary insurance (or personal insurance if WC/MVA) _____
Policy number _____ Group _____
Who is the policy holder? _____ DOB of policy holder _____
Phone number on card for provider services _____
Does your plan typically need a referral for specialists? _____Yes _____ No

Are you covered under a secondary insurance? If so, _____
Policy number _____ Group _____
Who is the policy holder? _____ DOB of policy holder _____
Phone number on card for provider services _____

Work/Motor vehicle insurance only
Name of insurance company _____
Claim number _____Date of accident _____
Adjustor/case manager phone number _____ extension _____
Patient's SSN _____ Policy # : _____

(WCOMP Only)
Employer Name/Phone: _____
Employer Address: _____

Do you know where we are located? Any questions that I can help with? Appointment date, time, and therapist