



## INTAKE FORM

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security Number \_\_\_\_\_ Occupation(s) \_\_\_\_\_

Work Status \_\_\_\_\_

Phone (Home) \_\_\_\_\_ Phone (Cell) \_\_\_\_\_

Email Address \_\_\_\_\_

DOB \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_ Marital Status \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

### Parent/Guardian/Significant Other

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Occupation(s) \_\_\_\_\_ Phone (Home) \_\_\_\_\_ Phone (Cell) \_\_\_\_\_

### Emergency Contact Information

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Occupation(s) \_\_\_\_\_ Phone (Home) \_\_\_\_\_ Phone (Cell) \_\_\_\_\_

### Insurance Information

Name of Insured \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Insurance Plan \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Contact Number \_\_\_\_\_

Fax Number \_\_\_\_\_



**PHYSICAL THERAPY  
& WELLNESS**  
*PREVENT. PRESERVE. PROGRESS.*

360 Physical Therapy & Wellness  
11840 West Market Place Suite G  
Fulton, MD 20759  
Phone: 301.957.2564  
Fax: 301.957.2565

### Physician Information

Name of Primary Care Physician \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

I hereby authorize the insurance carrier listed above to make payments directly to the healthcare provider *360 Physical Therapy & Wellness* and understand that I am financially responsible for all charges incurred that are not fully covered by my insurance. It is my responsibility to notify *360 Physical Therapy & Wellness* of any changes to my insurance plan otherwise I will be responsible for payment.

Name(Print) \_\_\_\_\_ Date \_\_\_\_\_

Signature (Patient or  
Caregiver) \_\_\_\_\_