360 PHYSICAL THERAPY & WELLNESS
PREVENT. PRESERVE. PROGRESS.

360 Physical Therapy & Wellness
11830 West Market Place Suite D
Fulton, MD 20759
Phone: 301.957.2564
Fax: 301.957.2565

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_____

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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)_____