AVANT
PHYSICAL THERAPY

PATIENT INTAKE FORM

PERSONAL INFORMATION

Legal name ..... Preferred name .....

Preferred pronouns ○ She/her ○ He/him ○ They/them ○ Other .....

Gender Identity ○ Female ○ Male ○ Transgender ○ Gender Non-Conforming/Non-binary ○ Additional .....

Sex at birth: ○ Female ○ Male ○ Prefer not to answer

Address ..... City/State ..... Zip .....

Date of Birth ..... Cell Phone ..... Email .....

Emergency contact ..... Relation to you .....

Emergency contact phone # ..... Interpreter/caregiver .....
(if applicable)

REFERRAL

Referring provider ..... Primary care provider .....

Referral source/how did you hear about us? .....

Have you seen a physical therapist this year? .....

Has anyone else treated you for this problem including massage therapists, acupuncturists, PT's? .....

HEALTH INSURANCE

Primary insurance company ..... Secondary insurance .....

Subscriber ID # ..... Group # .....

Group # ..... Subscriber ID # .....

Name of primary insured ..... Name of primary insured .....

DOB of primary insured ..... DOB of primary insured .....

Relation to primary ..... Relation to primary .....

AUTO OR WORK RELATED INJURY

Company .....

Claim number .....

Adjuster/claim representative name .....

Adjuster/claim rep phone number .....