**HANDS ON HEALTHCARE INC**

**INTAKE FORM**

**Personal Information** **Date:** _____

Name:_____ _____ ____
Last First initial

Address: _____ _____ ____ _____
Street City ST Zip

Phone(H)_____Phone(C)_____

Email: _____ Birthdate: _____ Age: _____ Sex: _____

Marital Status: S M W D If married Spouse name: _____

Emergency Contact: _____ Phone: _____

Employer: _____ Phone: _____

Empl. Address: _____ _____ ___ _____
Street City ST Zip

Date of injury or onset: _____ Related to work? _____ Auto Accident? ____ Other?____

Please explain how injury occurred:_____

_____

**INSURANCE INFORMATION**

**Primary Insurance:** _____Effective Date: _____

Name on Ins. Card _____

Insured's Birthdate:_____ Relation to Patient: _____

Insured's Employer: _____

ID # _____ Group #/Name _____

Insurance Address: _____ Phone: _____

**Secondary Ins.**:_____ Effective Date: _____

Name on Ins. Card _____ Relation to Patient: _____

Insured's Employer: _____ Insured's Birthdate: _____

ID # _____ Group #/Name _____

Insurance Address: _____ Phone: _____

Patient Name: _____

**Auto Insurance**

Ins. Co. Name: _____

Insured's Name: _____

Insured's Birthdate:_____ Relation to Patient: _____

Ins. Co. Address: _____

Ins. Co. Phone _____ Adjuster's Name _____

Policy # _____ Claim # _____

**Worker's Compensation**

Name of Employer: _____

Employer Address _____

Employer Phone: _____ Contact Person: _____

Ins. Co. Name: _____

Ins. Co. Address: _____

Ins. Co. Phone _____ Adjuster's Name _____

Claim # _____

**Release and Assignment**

I hereby authorize Hands on HealthCare, Inc. to release any necessary information acquired in the course of my exam and treatment to the insurance company for claim processing.

I also assign and request payment of medical benefits to Hands on HealthCare, Inc. for medical services. In addition, I understand that I am financially responsible for any charges not covered by insurance.

Print Patient's Name: _____

Patient Signature: _____ Date: _____