McCall Method | 61548 West Ridge Ave. | Bend, OR 97702
Lisa Ann McCall P.T. | 214-957-0234

PATIENT INTAKE FORM

NAME_____ DATE OF BIRTH_____ AGE _____

MAILING ADDRESS_____ CITY_____ ZIP_____

HOME PHONE (_____)_____CELL PHONE (_____)_____EMAIL_____

SSN_____-_____-_____ DRIVER'S LICENSE#_____EMPLOYED Y or N ***(please circle)***

EMPLOYER ***(only if circle Y)***_____

OCCUPATION_____ WORK PHONE (____) _____

REFERRING PHYSICIAN_____ PRIMARY PHYSICIAN_____

DATE OF INJURY_____ DATE OF SURGERY_____

HOW DID YOU HEAR ABOUT US? ***(if referred please give name)*** _____

PERSON TO CONTACT IN CASE OF EMERGENCY RELATIONSHIP_____

FIRST AND LAST NAME_____ PHONE(_____)_____

IF PATIENT IS A UNDER 18, PLEASE PROVIDE US WITH THE FOLLOWING INFORMATION:

PARENT/GUARDIAN NAME_____ SSN_____-_____-_____

PARENT/GUARDIAN EMPLOYER _____ WORK PHONE(_____)_____

INSURANCE COMPANY_____ **(*please present card @ time of service and please inform us if you have secondary insurance.)***

INSURANCE POLICY/ID NUMBER _____ GROUP NUMBER _____

RELATIONSHIP TO INSURED ***(circle one)*** SELF | SPOUSE | CHILD *if Spouse, provide spouses' b-day: _____

SECONDARY INSURANCE COMPANY _____

POLICY/ID NUMBER _____GROUP NUMBER_____

RELATIONSHIP TO INSURED *(circle one)* SELF SPOUSE CHILD

WAS THIS A MOTOR VEHICLE ACCIDENT_____**IF YES PLEASE COMPLETE THE FOLLOWING:**

NAME OF VEHICLE INSURANCE_____ PHONE (_____)_____

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PATIENT INTAKE FORM

NAME OF PERSON INSURED_____ ADJUSTER NAME _____

ACCIDENT CLAIM#_____

To the best of my knowledge, all insurance information has been provided on the above form. I authorize release of any medical information needed to process this claim. I hereby authorize payment of medical benefits to Lisa Ann McCall, PT. I also authorize Lisa Ann McCall, PT to represent me, if needed, before the Oregon Insurance Commissioner. I understand that I am financially responsible for any charges not covered by insurance and for cancellation with less than 24-hours notice.

Responsible Party's Signature	Patient's Signature	Date
_____	_____	_____