NATIONAL HEALTH FINANCE

NEW PATIENT INTAKE

HEALTHCARE PROVIDER INFORMATION

Your Name: _____ **Facility Name:** _____

Address: _____ **City:** _____ **State:** ___ **Zip Code:** _____

Email: _____ **Phone: (**___**)** ___ **-** _____ ☐ Office ☐ Cell

TREATMENT INFORMATION

Treatment Requested: ☐ Physical Therapy ☐ MRI/Imaging ☐ Ortho-Extremity ☐ Ortho-Spine ☐ Pain Management ☐ Neurology

☐ Psychological Evaluation ☐ Initial Medical Evaluation ☐ Other _____

Is Script/Order Available? ☐ Yes ☐ No

Type of Treatment & Frequency of Requested Treatment: _____

Is Patient Scheduled to Begin Treatment at Your Facility? ☐ Yes ☐ No **If yes, Date of Scheduled Treatment?** ___ **-** ___ **-** _____

PATIENT INFORMATION

Full Name: _____ ☐ Mr. ☐ Ms. **Language:** ☐ English ☐ Spanish ☐ Other _____

Phone: (___**)** ___ **-** _____ **Email:** _____ **DOB:** ___ **-** ___ **-** _____ **SSN:** ___ **-** ___ **-** _____

Address: _____ **City:** _____ **State:** ___ **Zip Code:** _____

Incident Date: ___ **-** ___ **-** _____

ATTORNEY INFORMATION

Law Firm: _____ **State:** ____

Law Firm Contact Name: _____

Email: _____ **Phone: (**___**)** ___ **-** _____ ☐ Office ☐ Cell

OTHER INFORMATION

Is there any additional information you would like to include that may be helpful?

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