Burkhardt
Physical Therapy Center, LLC

1555 Heritage Blvd.
West Salem, WI 54669
PH: (608)786-4989
FAX: (608)786-2321
Web: burkhardtpt.com

PATIENT INTAKE FORM

Date: _____

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Preferred Name: _____

DOB: _____ Age: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home: ( ) _____ Cell: ( ) _____ Work: ( ) _____

Have you had any physical therapy during this calendar year other than at Burkhardt Physical Therapy Center?

☐ Yes If yes, where? _____

☐ No

WOULD YOU LIKE TO RECEIVE AN APPOINTMENT REMINDER? (Circle one)

NO THANKS! *EMAIL* *CALL* *TEXT (Carrier Name):* _____

EMERGENCY CONTACT:

Last Name: _____ First Name: _____ Phone: _____

Relationship: _____

REFERRAL: How did you hear about Burkhardt Physical Therapy Center?

_____

****

HAVE YOU RETAINED A LAWYER? YES / NO If yes, name of Attorney: _____

REASON (PLEASE CHECK ONE) □ Personal Injury □ Auto Accident (*If so, which state):*_____

****

Patient or Guardian Agreement:

☐ I authorize release of my medical information requested by my insurance plan for payment.

☐ I understand that I am responsible for any balance due.

Signature of patient or guardian: _____ **Date:** _____/_____/_____