Orofino
Physical Therapy
& Wellness

PO Box 2546
1005 Michigan Avenue
Orofino, Idaho 83544
Office: (208) 476-9365
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PATIENT INTAKE FORM

Please Print Legibly

Personal Info	
Who referred you to OPT?	**Self A Past Patient Physician Other:**
Patient Name (Last, First, MI):	
Mailing Address:	
City, State, Zip Code:	
Home Phone #:	
Cell Phone #:	
Work Phone #:	
Email Address:	
Date of Birth (DOB):	
Social Security Number (SSN):	
Gender	Male Female
Marital Status	M S D W
Referring Physician:	
Date of Injury/ Surgery:	
Employer:	Is this a work related injury: Y N
Employer Address:	
City, State, Zip code:	
Occupation:	
Is there an attorney involved?	Yes No
Emergency Contact Person	Name: Phone #:
Relationship:	
Responsible Party Information/ Work Comp (person to be billed, only if different from above)	
Name (Last, First, MI):	
Date of Birth:	
Mailing Address:	
City, State, Zip Code:	
Phone Number:	
Gender:	Male Female
Social Security Number (SSN):	
Employer:	
Occupation:	
Relationship to Patient (circle): Self Spouse Parent Other	

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of Orofino Physical Therapy Notice of Privacy Practices on this day.

Signature:_____ Date:_____