Dr. Carr Integrative Physical Therapy
Please FAX to: 323.739.2737
Or email: drcarr@erincarrpt.com

NEW PATIENT INTAKE
MEDICARE VERIFICATION

You may fill this form by typing answers into this pdf and "save as" with new name, emailing, or printing/faxing. Or print blank and handwrite entries.

Appt Date:_________

Appt Time:_________

Is Appt. Pending Benefits?

Yes No

Name:____
(Exactly as appears on medicare)

Medicare ID#______________
(Including alpha-suffix)

Phone Number
____

Address:____

E-mail:____

DOB:__________

Referring Physician:____

Diagnosis /Body Part/ Weakness:____

Secondary or OTHER Insurance Information

Insurance Company:____

Secondary Insurance ID#_______________

Insurance Phone#
____

GROUP#____________________

Subscriber for Secondary Insurance?

Self Spouse

INSURED Name (If other than patient):____

INSURED DOB (If other than patient):___________