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

NEW PATIENT INTAKE
INSURANCE 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: _________

Is Appt Pending Benefits?

Yes **No**

Appt Time: _________

Name: ____

Phone(s): ____

Address: ____

E-mail: ____

Referring Physician: ____

Diagnosis /Body Part/ Weakness: ____

Insurance Company: ____

Insurance Phone#: ______________________

ID#: ____________________

GROUP# ____________

Patient's DOB _____________

Social Security# ____________________

Insured

Self

Spouse

Parent

INSURED Name (If other than patient): ____

INSURED DOB (If other than patient): ___________