Dr. Melissa Keras-Donaghy, DPT, CLT-LANA
Women's Health Physical Therapist
Certified Lymphatic Therapist

Intake Form
Client Registration

Client's Name:_____
(Last) (First) (M.I.)

Address_____
(Number and Street) (City) (State) (Zip)

Home Phone_____ Work Phone_____

Cell Phone _____ Primary Contact Number (circle): Home Work Cell

Email_____

Date of Birth_____ Social Security #_____

Referring Physician:_____Telephone:_____

Primary Physician:_____Telephone:_____

Emergency Contact: _____Telephone:_____

INSURANCE INFORMATION

Primary Insurance_____
Member #_____
Group # _____
Name of Insured _____
Insured SS#_____
Insured DOB_____

*How were you referred to Dr. Keras-Donaghy?*_____

I hereby authorize Dr. Keras-Donaghy, DPT, CLT-LANA to release any medical information necessary to assist in processing my claims and to apply for benefits on my behalf for covered services furnished to me. By signing below I certify that all the information that I have provided is true and correct to the best of my knowledge.

Signature_____

Date_____