

PATIENT DATA SHEET

First: _____ **MI:** _____ **Last:** _____

Date of Birth: _____ **Age:** _____ **Gender:** Male Female

Mailing Address: _____

Physical Address: _____

OK To Call	Phone:	Best Time To Call
<input type="checkbox"/>	Home: _____	_____
<input type="checkbox"/>	Work: _____	_____
<input type="checkbox"/>	Cell: _____	_____

SSN: _____

Email: _____
Would you like to be contacted by email? Yes No

Preferred language: _____
Intepreter required?

Married Single Divorced Widowed Separated Unknown

Student Status: Full-Time Part-Time None

Date of Injury: _____ **Referring Physicain:** _____
Injury Area: _____
Auto or Work Accident: _____

EMPLOYMENT STATUS

Employment Status:

Active Military Full-Time None Part-Time Retired Self Employed

PATIENT EMPLOYER INFORMATION

Employer:

Occupation:

Address:

Phone:

SPOUSE EMPLOYER INFORMATION

Employer:

Occupation:

Address:

Phone:

INSURANCE INFORMATION

Primary Insurance

Policy Holder's Name:

Holder's Birth Date:

Policy or Certificate #:

Group #:

Policy Holder's Employer:

Secondary Insurance:

Policy Holder's Name:

Holder's Birth Date:

Policy or Certificate #:

Group #:

Policy Holder's Employer:

Are you receiving or have you received Home Health Services? Yes No

Are you receiving or have you received other therapy services? Yes No

How did you hear about us?

- | | | |
|---|---|---|
| <input type="checkbox"/> Physician | <input type="checkbox"/> Hospital | <input type="checkbox"/> Marketing Ad - Print |
| <input type="checkbox"/> Employer | <input type="checkbox"/> Cross Referral | <input type="checkbox"/> Marketing Ad - TV |
| <input type="checkbox"/> Case Manager | <input type="checkbox"/> Friend - Word of Mouth | <input type="checkbox"/> Marketing Ad - Billboard |
| <input type="checkbox"/> Former Patient | <input type="checkbox"/> Attorney | <input type="checkbox"/> Marketing Ad - Direct Mail - Email |
| <input type="checkbox"/> Adjustor | <input type="checkbox"/> Self | <input type="checkbox"/> Marketing Ad - Facebook |
| <input type="checkbox"/> School | <input type="checkbox"/> Screens - Open Houses | <input type="checkbox"/> Marketing Ad - Other _____ |

Specify if other : _____

Note: Please provide us with the most updated information down below.

CONTACTS

Name	Phone	Work	Cell	Fax	Type
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Signature of Patient

Date

PATIENT INTAKE AND CONSENT FORM

Please Initial Each as Applicable:

Internal Use Only: A/C# Name A/C Type Office #

CONSENT TO TREATMENT

I consent to rehabilitation and related services at:

In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature.

TREATMENT OF MINORS:

I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.

LIABILITY

I know and agree that:

is not responsible for loss or damage to personal valuables.

WAIVER AND RELEASE

I hereby release, discharge and acquit:

its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.

AUTHORIZATION OF PAYMENT

I hereby assign all benefits directly to:

I also authorize release of any medical records necessary to facilitate my treatment to process medical claims and otherwise permitted or required in the Notice Of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

NOTICE OF PRIVACY

I acknowledge receipt of Notice of Privacy Practices.

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature Witness Signature