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**
☐	Home: ____________	____________
☐	Work: ____________	____________
☐	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?

- ☐ Physician
- ☐ Employer
- ☐ Case Manager
- ☐ Former Patient
- ☐ Adjustor
- ☐ School
- ☐ Hospital
- ☐ Cross Referral
- ☐ Friend - Word of Mouth
- ☐ Attorney
- ☐ Self
- ☐ Screens - Open Houses
- ☐ Marketing Ad - Print
- ☐ Marketing Ad - TV
- ☐ Marketing Ad - Billboard
- ☐ Marketing Ad - Direct Mail - Email
- ☐ Marketing Ad - Facebook
- ☐ Marketing Ad - Other ____________

Specify if other : ______________________________

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

CONTACTS

Name	Phone	Work	Cell	Fax	Type

______________________________ ____________

Signature of Patient **Date**

Please Initial Each as Applicable:

PATIENT INTAKE AND CONSENT FORM

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 ____________________