PATIENT DATA SHEET

First: MI: Last:

Date of Birth: Age: Gender: Male ☐ Female ☐

Mailing Address: _____

_____

_____

Physical Address: _____

_____

_____

_____

May we send you text messages relating to your care with us? ☐ Yes ☐ No

By providing your text number below, you understand that text messages will NOT be sent via secure, encrypted format.

OK To Call	OK To Text	Phone:	Best Time To Call
☐	☐	Home: _____	_____
☐	☐	Work: _____	_____
☐	☐	Cell: _____	_____

SSN:

May we send you emails relating to your care with us? ☐ Yes ☐ No

By providing your email address below, you understand that emails will NOT be sent via secure, encrypted format.

Email: _____

Preferred language:
Intepreter required? ☐ Yes

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Unknown

Student Status: ☐ Full-Time ☐ Part-Time ☐ None

Date of Injury: _____ Referring Physician: _____

Injury Area: _____

Auto or Work Accident: _____

EMPLOYMENT STATUS

Employment Status:
☐ Active Military ☐ Full-Time ☐ None ☐ Part-Time ☐ Retired ☐ Self Employed

Employer: Occupation:

Address:

Phone:

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

Specify if other : _____

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

CONTACTS

DISCLOSURE OF MEDICAL RECORDS

I authorize the following individuals to have access to my medical and billing records:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
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 to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary 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 _____