

Patient Information Form

Patient Demographic Information				
*Last Name		*First Name		*Middle Initial
Address		City	State	Zip Code
*Home Phone	*Appointment Reminder Contact Method <input type="checkbox"/> Text <input type="checkbox"/> Mobile <input type="checkbox"/> Email <input type="checkbox"/> Home Phone (Choose method of choice) <input type="checkbox"/> No Appointment Reminder			
*Mobile Phone	*Email Address <input type="checkbox"/> Declined Email <input type="checkbox"/> No Email			
*Date of Birth	SSN	*Sex <input type="checkbox"/> F <input type="checkbox"/> M	Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other	
Employer Information				
Employer		Employment Status <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> None <input type="checkbox"/> Retired <input type="checkbox"/> Student		
Address		City	State	Zip Code
Work Phone		Occupation		
Emergency Contact Information				
Contact Name		Phone	Relationship	
Physician Information				
Referring Physician		Phone	Script Date	
Additional Questions				
Injury /Onset Date		Post-Surgical <input type="checkbox"/> Yes <input type="checkbox"/> No	Surgery Date	Body Part/DX
Work Related <input type="checkbox"/> Yes <input type="checkbox"/> No	Accident Related <input type="checkbox"/> Yes <input type="checkbox"/> No	Auto Related <input type="checkbox"/> Yes <input type="checkbox"/> No	Attorney Involved <input type="checkbox"/> Yes <input type="checkbox"/> No	
Adjuster/Nurse Cases Mgr.		Phone	Attorney	Phone
Have you had prior Therapy this year? (PT/OT/SP/Chiro) <input type="checkbox"/> Yes <input type="checkbox"/> No			How did you hear about us?	
Medicare ONLY! Additional Questions				
If Medicare, are you currently Receiving HomeHealth Services? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If YES, Name of Agency		If discharged what is last date of service?		
Are you currently residing in a Skilled Nursing Facility? If Yes, Name of facility				
Primary Insurance Section		Secondary Insurance Section		
*Insurance/Plan		*Insurance/Plan		
*Policy ID #		*Policy ID #		
*Group #		*Group #		
*Insurance Phone		*Insurance Phone		
Are you the policy holder? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, continue		Are you the policy holder? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, continue		
Card Holder Name		DOB	Card Holder Name	DOB
Patient Relationship to Policy holder <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child		Patient Relationship to Policy holder <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child		
Patient, Please initial here if the above information is correct and complete			Date	

Office Staff use ONLY (below)		
Intake Completed by	Date	*Date Eval Scheduled
Registered by	Date	Acct #
Patient Service Specialist will initial next to each task below once completed.		
Billing Disclosure added in RT Comments <input type="checkbox"/>	Verified DL/Photo ID <input type="checkbox"/>	Consent to receive calls and/or text messages, reviewed with patient. If patient agrees and signed consent, is text enabled box checked in RT? <input type="checkbox"/>