



Patient Information Form

INTERNET FORM

Patient Demographic Information					
*Last Name		*First Name		*Middle Initial	
Address		City	State	Zip Code	
*Home Phone	*Appointment Reminder Contact Method (Choose method of choice)			<input type="checkbox"/> Text <input type="checkbox"/> Mobile <input type="checkbox"/> Email <input type="checkbox"/> Home Phone <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"/>