MR #:
Patient Name:

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 secure, with a risk of unauthorized access to your information.

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 email communications may NOT be secure, with a risk of unauthorized access to your information.
Email: ____________________

Preferred language:
Interpreter 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: ____________

MR #:
Patient Name:

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

MR #:
Patient Name:

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

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**

MR #:
Patient Name:

Please Initial Each as Applicable:

PATIENT INTAKE AND CONSENT FORM

Internal Use Only:	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/PATIENT BILL OF RIGHTS

I acknowledge receipt of Notice of Privacy Practices. ________________

I acknowledge receipt of the Statement of Patient Rights. ________________

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

Patient/Guardian Signature ____________________ Witness Signature ____________________