Patient Information

First name: ________________________________ MI: _____ Last name: ____________________________________

Address 1: ____

City: ____ State: _____________ Zip Code: _____________

Home phone: ______________________ Cell phone: ____________________ Date of birth: __________________

Please circle first contact preference

Social Security Number: _____________________ Email Address: ____

Employer and employer phone number: ____

Employer address: ____

General physician: ____

Second contact person name: ____

Second contact person address: ____

Phone number: ______________________________ Relation: ____

Work related? Yes No If yes, date of injury: ____

Related to a motor vehicle accident? Yes No If yes, state and date of accident: ________________________________

How did you hear about us? ☐ Physician Referral ☐ Family or Friend ☐ Industry

☐ Other (please list): ____

I authorize the staff of this rehabilitation facility to provide treatment to me as directed by my referring physician. I authorize the release of any medical information necessary and as stated in the previous privacy policies. I authorize the release of clinical information to my referring physician.

Signature: ____ **Date:** _____________

Parent/legal guardian signature: _____________________________________ Date: _____________

Relationship to the patient: ____

_____ I have been given the Notice of Privacy Practice, AND have been made aware, and copies available to me, of the Rights. If I have any questions, I can contact the Compliance Officer at 812-488-2579.

Patient Initials