

# REHABILITATION TODAY

## Patient Information Sheet

Initial Registration Site:  Olean  Cuba  Arcade  Bradford  
Referral Date \_\_\_/\_\_\_/\_\_\_ Initial Contact Date \_\_\_/\_\_\_/\_\_\_  
Date Scheduled \_\_\_/\_\_\_/\_\_\_ Appt Time \_\_\_\_\_ Therapist \_\_\_\_\_  
Comments \_\_\_\_\_

Meeting the needs of tomorrow...

Patient Name \_\_\_\_\_ Address \_\_\_\_\_ Sex: Male/Female  
Date of Birth \_\_\_/\_\_\_/\_\_\_ Age \_\_\_ City, State & Zip \_\_\_\_\_  
SSN \_\_\_-\_\_\_-\_\_\_ Home Telephone Number \_\_\_-\_\_\_-\_\_\_ Cell Phone \_\_\_-\_\_\_-\_\_\_  
Emergency Contact Name and Phone Number \_\_\_\_\_  
Patient's Employer \_\_\_\_\_ Work Phone Number \_\_\_-\_\_\_-\_\_\_  
Employer Address \_\_\_\_\_ City, State & Zip \_\_\_\_\_  
Referring Physician \_\_\_\_\_ Last MD appt \_\_\_/\_\_\_/\_\_\_ Next MD Appt \_\_\_/\_\_\_/\_\_\_  
Date of Injury or Onset \_\_\_/\_\_\_/\_\_\_ Diagnosis \_\_\_\_\_ Surgery Date \_\_\_/\_\_\_/\_\_\_  
Is this a Work Related Injury?  YES  NO  
Motor Vehicle accident injury?  YES  NO  
Have you been off work due to the injury?  YES  NO If yes, what was the date last worked \_\_\_/\_\_\_/\_\_\_  
Are you able to leave the clinic independently?  YES  NO  
Have you ever received any type of Home Health Care?  YES  NO  
If yes, what was the name of the Home Health Care Agency? \_\_\_\_\_  
When was the last date you receive this care (approximate date)? \_\_\_\_\_  
Have you received any Physical /Occupational/Speech Therapy this year?  YES  NO  
If yes, where were the services rendered and how long did you receive treatment? \_\_\_\_\_

### INSURANCE INFORMATION

Primary Insurance Company \_\_\_\_\_ Phone Number \_\_\_-\_\_\_-\_\_\_  
Insurance Carrier Name & Relationship \_\_\_\_\_  
Insurance Carrier Date of Birth \_\_\_/\_\_\_/\_\_\_ Employer \_\_\_\_\_  
Insurance ID # \_\_\_\_\_ Group # \_\_\_\_\_ Co-pay Amt \_\_\_\_\_  
Referral Required?  YES  NO Claim Handler \_\_\_\_\_ Ext \_\_\_\_\_  
Secondary Insurance Company \_\_\_\_\_ Phone Number \_\_\_-\_\_\_-\_\_\_  
Insurance Carrier Name & Relationship \_\_\_\_\_  
Insurance Carrier Date of Birth \_\_\_/\_\_\_/\_\_\_ Employer \_\_\_\_\_  
Insurance ID # \_\_\_\_\_ Group # \_\_\_\_\_ Co-pay Amt \_\_\_\_\_  
Referral Required?  YES  NO Claim Handler \_\_\_\_\_ Ext \_\_\_\_\_

### Additional Insurance Information \_\_\_\_\_

Please inform us and write below the name, phone/fax, and/or address of any additional physicians that you wish to be furnished with a copy of your evaluation. Referring physician will routinely be furnished with a copy.

Physician Information \_\_\_\_\_

### Workers' Compensation patients must initial, date and indicate yes or no below:

I hereby authorize REHABILITATION TODAY, Medical Provider to furnish my employer with a complete report of my evaluation, diagnosis, and treatment plan of care in regard to my Physical, Occupational, and/or Speech Therapy status.  YES  NO Initials \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

4/3/07

