PATIENT INFORMATION

TODAYS DATE: ______________ PATIENTS NAME: ____________________________________ DOB: __________

APPOINTMENT DAY/TIME: _____________________REFERRED BY: ______________________________________

DIAGNOSIS: ____________________________________SURGERY DATE: _________________________________

PLEASE CIRCLE: MALE/FEMALE MARITAL STATUS: M/S/D/W

HOME ADDRESS: ____ HOME#: _____________________

____ CELL#: _______________________

EMAIL ADDRESS: ____

SS#: ______________________ EMPLOYER: ___________________________ WORK#: _____________________

INSURANCE INFORMATION

INSURED NAME: _____________________________ INSURED SS#:___________________DOB: ______________

EMPLOYER:____ RELATIONSHIP: SELF/SPOUSE/CHILD/WORK COMP

PRIMARY INS: ______________________________________PHONE#: ___________________________________

ADDRESS:_______ _______________________________________ ID#________________GRP#:______________

_______I HEREBY CONSENT TO MEDICAL TREATMENT BY CORE REHABILITATION GROUP THAT IS CONSIDERED NECESSARY AND APPROPRIATE FOR DIAGNOSIS AND TREATMENT OF A PHYSICAL CONDITION I MAY HAVE. I UNDERSTAND THAT I WILL BE INFORMED OF ALL PROCEDURES AND ASPECTS OF TREATMENT SO THAT I MAY MAKE WELL INFORMED DECISIONS. I AM ALSO ACKNOWLEDGING THE RECEIPT OF PRIVACY POLICIES AND PRACTICES NOTICE AS REQUIRED BY HIPPA.

_______I HEREBY RELEASE MY PERSONAL HEALTH INFORMATION AND MY INSURANCE INFORMATION TO CORE REHABILIATION GROUP FOR THE PURPOSES OF COMMUNICATION WITH OTHER HEALTHCARE PROFESSIONALS DIRECTLY INVOLVED IN MY CARE. I UNDERSTAND THAT MY PERSONAL HEALTH INFORMATION WILL BE UTILIZED FOR PAYMENT OF SERVICES RENDERED AND AM GIVING CORE REHABILITATION GROUP PERMISSION TO FILE MY INSURANCE.

I HAVE READ A COPY OF THE ABOVE TERMS AND ATTEST ALL THE INFORMATION GIVEN ABOVE IS CORRECT.

_______________________________________ __________________

PATIENT/LEGAL GUARDIAN/RESPONSIBLE PARTY DATE