CROUSE
REHAB ASSOCIATES

PLEASE GIVE THE RECEPTIONIST A COPY OF YOUR DRIVER'S LICENSE AND INSURANCE ID CARD

Thank You

PATIENT INFORMATION SHEET

Today's Date _____ How did you hear about us? _____

Patient's Name _____ Date of Birth ____/____/____
First Middle Last Month Day Year

Street Address: (No P.O. Box Please) _____
Street

_____
City State Zip

Social Security Number _____ Home Phone # (____) _____
Area Code

Marital Status M, S, W, D Age _____ Sex M F
Please Circle One Please Circle One

In case of emergency, please contact: _____ Ph # _____ Relationship _____

Employer/School _____ Occupation/Position _____

Employer's Address _____ Work # _____

Parent or Guardian name (if patient is a minor) _____ Date of Last MD Visit _____

Address _____

Father's Employer _____ Work # _____

Mother's Employer _____ Work # _____

Spouse Name _____ DOB _____

Spouse's Employer _____ Work # _____

Position/Occupation _____ SS# _____

Please describe your injury or area of pain for which you are being seen today _____

_____

Was your injury due to an accident? Yes No If yes, was it job related? _____ Was your injury due to an automobile accident? _____

Please explain how your injury occurred. _____

_____ Date of injury? ____/____/____
Month Day Year

Auto Insurance Information on the vehicle you were in: Carrier _____ Policy Number _____

Adjuster _____ Claim # _____ Phone # _____

Insurance Information

Do you have Medicare Coverage? _____ ID# _____

If yes, are there any primary payers other than Medicare? _____

If yes, please give information _____

Are you currently employed? _____ Full Time or Part Time

Primary Carrier _____ ID# _____

Group # _____ Phone # _____

I certify that the above information that I have given is accurate and true to the best of my knowledge. _____
PLEASE INITIAL

CONSENT TO TREAT

I hereby voluntarily consent to receive treatment for my condition according to my treatment plan. I have been informed by my therapist of the treatment procedures to be utilized, including information about significant risks, benefits of and alternatives to the procedures and have had my questions answered. I understand this (these) treatment(s) will be performed by an appropriately credentialed staff member employed by or acting as an agent of Crouse Rehab Associates. I further understand that I may rescind this consent at any time and will be informed of the potential consequences of that decision.

Patient/Legal Guardian _____

Witness _____ Date _____

DO NOT WRITE IN THIS BOX

Account # _____

Referring Physician _____

ICO9 code _____

Medicare Trauma Code _____

Medicare Occurrence Date _____

Verified _____ Initials _____