



FOR OFFICE USE ONLY:

PIN: _____ THERAPIST: _____ Tx Diagnosis _____
 RECORD #: _____ Blood Pressure : _____ MmHg Pulse : _____ bpm O2 : _____ %

PATIENT INFORMATION & MEDICAL HISTORY

NAME : _____ **TELEPHONE: ()** _____ **E-Mail:** _____
SOCIAL SECURITY NUMBER: _____ **Date of Birth:** _____ **AGE:** _____ **GENDER:** _____
ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____
EMERGENCY CONTACT: _____ **TELEPHONE: ()** _____
REFERRING PHYSICIAN: _____ **PRIMARY PHYSICIAN:** _____
REASON FOR THERAPY: _____ **DATE OF INJURY/ILLNESS:** _____

General Medical Information: Please fill out all the needed information and affix your signature on the spaces provided.

Do you now have or have you had any of the following?

- | | | |
|---|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart disease | <input type="checkbox"/> Yes <input type="checkbox"/> No Back problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Poor eyesight/hearing |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart attack / Heart By Pass | <input type="checkbox"/> Yes <input type="checkbox"/> No Metal Implants | <input type="checkbox"/> Yes <input type="checkbox"/> No History of Cancer |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker / Stent | <input type="checkbox"/> Yes <input type="checkbox"/> No Muscular Dystrophy | <input type="checkbox"/> Yes <input type="checkbox"/> No Seizure/Epilepsy |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatoid Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No Polio |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Hypertension | <input type="checkbox"/> Yes <input type="checkbox"/> No Osteoarthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No Multiple sclerosis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Low blood pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No Gout |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Fibromyalgia | <input type="checkbox"/> Yes <input type="checkbox"/> No Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Carpal tunnel syndrome | <input type="checkbox"/> Yes <input type="checkbox"/> No Joint Replacement | <input type="checkbox"/> Yes <input type="checkbox"/> No Fainting spells |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of breath | <input type="checkbox"/> Yes <input type="checkbox"/> No Joint Dislocation | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Nervous disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No Circulatory disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No Allergies |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Sensitivity to Heat/Cold | <input type="checkbox"/> Yes <input type="checkbox"/> No COPD | <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis /Infectious Dis. |

Yes No Are you presently taking medication? If yes, please specify: _____

Yes No Have you had therapy for your present condition? If yes, please provide details: _____

Yes No Is your injury job-related or a result of a vehicular accident? If yes, please answer the questions on the next page as well.

If you have answered YES to any of the questions above _____
 please explain and give approximate dates: _____

INSURANCE INFORMATION

PRIMARY INSURANCE

Name of Policyholder: _____
 Relationship to Patient: _____
 Date of Birth: _____
 SS#: _____
 Insurance Co: _____
 Policy #: _____

SECONDARY INSURANCE

Name of Policyholder: _____
 Relationship to Patient: _____
 Date of Birth: _____
 SS#: _____
 Insurance Co: _____
 Policy #: _____

ASSIGNMENT & RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Mountaincrest Rehabilitation all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Mountaincrest Rehabilitation for any services rendered to me by the Provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other insurance" is indicated in item 9 of the HCFA 1500 Form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medical carrier.

I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep Mountaincrest Rehabilitation updated as to any changes in my medical profile and understand that there shall be no liability on the Provider's part should I fail to do so. By my signature, I hereby certify that all the information provided is true and correct. Moreover, my signature signifies my agreement to the insurance and Medicare clauses stated above.

PATIENT SIGNATURE: _____ **DATE:** _____