PERRYSBURG REHABILITATION

Demographic Data and Account Information

Please Print:

First Name ______ Initial ______ Last Name ______ Social Security Number ______

Home address ______ City ______ State ______ Zip Code ______

Home Phone ______ Work Phone ______ Cell Phone ______ E-mail Address ______

Date of Birth ______ Marital Status ______ Employer ______ Occupation ______

Primary Insurance ______ Policy Number ______ (Bring card to initial visit)

Secondary Insurance ______ Policy Number ______ (Bring card to initial visit)

Emergency Contact ______ Address ______ Relationship ______

Emergency Contact Home Phone ______ Emergency Contact Work Phone ______ Emergency Contact Cell Phone ______

The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of protected health information. To that end, please indicate your preference in contacting you (check all that apply):

Home Telephone:
- ☐ O.K. to leave appointment reminder notice only
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

Work Telephone:
- ☐ O.K. to leave appointment reminder notice only
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

Written Communication:
- ☐ Do not mail or fax written communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to an alternative address: ______
- ☐ O.K. to fax to this number: ______

RECEIPT OF PRIVACY PRACTICE POLICY: I have received a copy of the PERRYSBURG REHABILITATION, PRIVACY PRACTICES POLICY.

GUARANTEE OF ACCOUNT: For consideration of services rendered by Perrysburg Rehabilitation. I understand that I am responsible for charges not paid by my insurance company. I instruct my insurance company to issue payment directly to Perrysburg Rehabilitation.

Print Patient Name ______ Signature of Patient or Guardian ______ Date ______

____ YES ____ NO My illness or injury is the result of an automobile accident.

____ YES ____ NO My illness or injury is the result of a work related incident.

____ YES ____ NO I have had prior physical therapy for this illness/injury.

If yes:

Name of facility ____

Treatment dates from ______________ through ________________

Number of treatments __________

____ YES ____ NO I have had physical therapy for another illness/injury in the past 12 months.

If yes:

Name of facility ____

Treatment dates from ______________ through ________________

Number of treatments __________

____ YES ____ NO I have had chiropractic treatment for this or another illness/injury in the past 12 months.

________________ Date of injury or onset of symptoms.

Give a brief description of illness or injury ____

How were you referred to Perrysburg Rehabilitation? ____