PATIENT INFORMATION

SCHNECK
REHABILITATION SERVICES

Name:_____ DOB:_____

Best Phone Number to Contact you: _____

Email Address:_____

Referring Physician:_____

Next Appointment with Referring Physician:_____

Primary Care Physician:_____

Please list, or supply a copy of, the medications you are currently taking:

_____

_____

Have you had any recent: X-ray MRI Bone scan CT Scan
(Regarding this Diagnosis) Other:_____

Do you have, or have you had, any of the following (circle):

Diabetes	High blood pressure	Pacemaker	Cancer
Seizures	Head injury	Stroke	Osteoporosis

Allergies:_____ Other:_____

Please list any medical treatment related to current problem/diagnosis:

_____

Have you had any previous therapy? Yes / No
If so, explain:_____

"I understand it is my responsibilities as a patient to:

- Check with my insurance company for any prior authorization needed
- Let the therapist know if he/she needs to fill out insurance forms

I understand that:

- I may be responsible for any charges incurred for Rehab Services (wound care, physical, occupational, and/or speech therapy)
- After three (3) no-show/cancellations, I will be discharged from Rehab Services and my physician will be notified."

_____ Date: _____
(Patient/Guardian Signature)