

PATIENT INFORMATION SHEET

Patient Name: _____ Date of Birth: _____ Age: _____

Address _____ City _____ State _____ Zip _____

Home Phone: _____ Work Number: _____ E-Mail: _____

Occupation _____ Employer Name _____

Address _____ City _____ State _____ Zip _____

Employer Status: (circle one)
Not Employed Full Time Part Time Student [PT/FT] Retired

Nature of Accident: _____ **Date of Injury:** _____

- Injured at home? Is this a Work Comp. Injury? Yes / No
- Injured at school? *Referring Provider: _____
- During recreation? Referral Source: _____ Next MD Appt: _____
- Work injury? Are you currently working? Yes / No
- Accident/Off-Road Social Security #: _____
- Vehicle Collision? Driver's License #: _____

Married Divorced Single Widowed Legally-Separated Child or Minor

➤ Work Comp Claim Number (prior authorization number): _____

Spouse/Partner Name _____ Occupation _____

Employer _____ Phone _____

Primary Insurance Company Name: _____ Address: _____
ID/Subscriber Number# _____ Group No #: _____ Plan# _____ O.V. Co-Pay: \$ _____
Name of Responsible Party if *different* than Patient _____ DOB: _____
Employer/Group Name: _____ SS #: _____

Secondary Insurance Carrier _____

ID/Subscriber Number# _____ Group Number _____ Plan # _____

Name of Responsible Party if different than Patient _____ DOB: _____

Address _____ Relationship to Patient: _____

I authorize the release of any medical or other information necessary to process claims on my behalf. I also agree to be fully responsible for all lawful debts incurred by myself for services received from Tech Coast Rehab, Inc. and consent to medical treatment, whether covered by insurance or not.

Patients Signature: _____ Date: _____

Medical History

Patient Name: _____

Do you have/or had any of the following?

(please check all that apply)

- Diabetes
- High Blood Pressure
- Heart Disease
- Heart Attack
- Pacemaker
- Headaches
- Kidney Problems
- Nervous Disorders
- Circulatory Disorder
- History of Cancer
- Sensitivity to Heat
- Sensitivity to Ice/Cold
- Previous Surgery
- Seizures
- Metal Implants
- Currently Pregnant
- Allergies _____
- Other Illnesses _____

Referring Physician: _____

Are you currently taking any medication??

If so, please list: _____

Please describe type of pain (*burning, aching, stabbing, shooting*). Include location of pain and frequency; also list **time of day** when pain is *most* severe.

Patient Name: _____

Medical Record #: _____