□ Bridgeton Health Center □ Elmer □ Sports Rehabcare □ Tomlin Station Rehabcare □ Vineland Health Center

☐ **New Treatment Series/Already Registered** **NEW PATIENT REGISTRATION**

Intake completed by: _____Date:__________

PATIENT INFORMATION

Patient Name: ____ Home phone: (____) ______________cell(____)__________________
Address: ____City____________________________State: _____ Zip: __________
Date of birth: _____/______/_______ Social Security #:______________________________ Marital Status: ____ Sex: __ M /__ F

Employer Information:

Name of Employer:____Self / Spouse *(circle one)*
Address: ____ City: ____________________________ State: ____ Zip: _________
Occupation: ____Work phone: _______________________

Guarantor Information (if other than self):

Name: ____Home phone: (____)__________________ SS # :______________________
Address: ____ City: ______________________________ State: ________ Zip: ________
Date of birth: ____/____/____ Sex: __ M /__ F Marital Status ________ Relationship to patient: ____________________

Relative / Emergency Contact:

Name: _____________________________Relationship: ______________Home Phone: (_____) ___________Work Phone: (______)__________

Are you currently experiencing flu like symptoms such as: fever, headache, muscle aches, weakness, nausea, vomiting, diarrhea? Yes No
Have you recently traveled outside of the US? If so, where? ______________________________

MEDICAL / PHYSICIAN INFORMATION:

Referring Physician: ____Phone #:(____)____________Fx #:(____)_________________
Address: ____ City: ___________________________ State: __________ Zip: ______
Primary Care Physician: ____Phone #:______________________Fx #:_______________
Admitting Diagnosis: ____**ICD9 Code:**_________________________________
Surgery Date: ____ Type of Surgery: ___________________________________

PATIENT ORIGIN:

☐ HOST MED SURG	☐ OTHER INPATIENT REHAB
☐ OTHER MED SURG	☐ HOST HOME HEALTH
☐ Occupational Health	☐ OTHER HOME HEALTH
☐ COMMUNITY	☐ Employee

Hospital Employee: Yes______ No_______

INSURANCE INFO:

____ Worker's Comp ____ Medicare _____ Motor Vehicle Accident ____ Copay
____ Managed Care ____ Medicaid _____ Managed Medicare _____ Referral
____ Commercial ____ Self Pay _____ Charity Care

☐ **Employer / Patient single case agreement**

Primary:

Company: _____________________________Address: __________________________________ City: ___________ State: ___ Zip: _______
Phone: (______)_____________________Name of Insured (if other than self): _________________ Soc. Sec.#: _______________________
Policy/ID#: ___________________________________ Group: ________________________________Effective Date: __________________
Case Manager: ____Phone: (________)____________________________ ext. _________
If MVA, Date of Accident: _________/_________/_________ Time: _____am/pm Claim number: _____________________________________

Secondary:

Company: ____ Phone: (__________)_________________
Address: _______________________________________ City: ___________________________________ State: ________ Zip: ___________
Insured's Name: ____ SS # : ____
Policy ID#: ___________________________ ________________Group #:______________________________ Effective date: ____________

MEDICARE ONLY: Are you covered by any of the following: workers comp, Black lung, HMO, Veterans Benefits,
Employee Group Insurance? If so explain. ____
Have you been admitted to SNF or Hospital in last 60 days? If so Where and When? ________________________________
____If so explain______________________________
Is this a result of an accident? _______What:_______________Where:_________________When:______________________
Are you receiving benefits because you are disabled or have you met benefit age? ☐ Disabled ☐ Age 65 or over

Additional Information: (*For Office Use Only*
Referral Date: ________/_________/__________ **Onset Date:**____/________/____ **First Visit**: _______/_______/_______ Time:____________
Therapy Ordered: ______________________________________ Therapist: ______________________________________

Referring Program: **LifeSpine** **General** **Hand** **Lymphedema** **Urinary Incontinence** **Vestibular** **Speech** **10/28/13**

Name: ______________________________

Insurance Authorization Approvals:

Reference #____
Insurance Contact: ____________________________ Date: _________________ Called by: ___________
Auth/Referral #: ____________________________ # visits: _______________ Expires: __________
Co-pay amount $_________ Reimbursement % ______(in network) _______(out of network)
Deductible $______________ met / unmet
Out of pocket Maximum: $_________ Out of pocket remaining: $ ___________

Reference #____
Insurance Contact: ____________________________ Date: _________________ Called by: ___________
Auth/Referral #: ____________________________ # visits: _______________ Expires: __________
Co-pay amount $_________ Reimbursement % ______(in network) _______(out of network)
Deductible $______________ met / unmet
Out of pocket Maximum: $_________ Out of pocket remaining: $ ___________

Reference #____
Insurance Contact: ____________________________ Date: _________________ Called by: ___________
Auth/Referral #: ____________________________ # visits: _______________ Expires: __________
Co-pay amount $_________ Reimbursement % ______(in network) _______(out of network)
Deductible $______________ met / unmet
Out of pocket Maximum: $_________ Out of pocket remaining: $ ___________

Reference #____
Insurance Contact: ____________________________ Date: _________________ Called by: ___________
Auth/Referral #: ____________________________ # visits: _______________ Expires: __________
Co-pay amount $_________ Reimbursement % ______(in network) _______(out of network)
Deductible $______________ met / unmet
Out of pocket Maximum: $_________ Out of pocket remaining: $ ___________

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ADDITIONAL COMMENTS:____

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