Kessler Rehabilitation Center	Office Use Only		
Past Patient: ☐ YES ☐ NO	Patient Account # _______________ M R # _________________ Clinic Name: ___ ___________________________________		Evaluation Date: Date of prescription:
Diagnosis 1 (Desc/ICD9):	Diagnosis 2 (Desc/ICD9):	Onset Date:	☐ PT ☐ OT ☐ Other

Patient Information

Patient Name: (First, MI, Last, - Sr., Jr., etc)			SS #: - -
Address:	City	State:	Zip Code:
Telephone:	Date of Birth (mm-dd-yyyy)	Sex: ☐ M ☐ F	**Status**: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Unknown
Email Address:			

Race/Ethnicity: ☐ American Indian or Alaska Native ☐ Asian/Pacific Islander ☐ Black or African American ☐ White ☐ Hispanic or Latino ☐ Multiracial ☐ Declined ☐Unavailable

Date of Injury / Onset Date	Auto Related: ☐ Yes - State? ________ ☐ No	Work Related: ☐ Yes ☐ No	Adjustor Name & Telephone #:

If Workers Comp, was accident with present Employer? ☐ No ☐ Yes If No, who was employer? __________________________________ Occupation: ____	If Auto Accident: Date of Accident: ____ / ____/ ____ Type of Accident: Driver / Passenger / Pedestrian / Job / Fall / Other

Do you have Medicare? ☐ **No** ☐ **Yes** **Are you currently receiving Home Health Services?** ☐ **No** ☐ **Yes**

If Yes, name of agency & what type of Home Health Services are you receiving? ____

If No, have you received services in past 60 days ______If yes, Name of Agency & last Date of Service______________________________________

Were you ever treated for Out Patient Physical Therapy before? ☐ No ☐ Yes

Are you currently residing in a Skilled Nursing Facility? ☐ No ☐ Yes If yes, Name of Facility? ________________________________

If Yes, are you on/in the “Medicare Unit”? ☐ No ☐ Yes

Primary Insurance Information

Name of Insurance Company:	Policy or Claim #:	Group # / Policy Holders Employer:
Policy Holder Name:	Date of Birth:	Social Security #
Insurance Company Telephone #:	Policy Holders Work Phone #:	**Patient Relationship to Policy Holder:** ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Secondary Insurance Information (Backup if Auto, Workers Comp. or Litigation)

Name of Insurance Company or Attorney:	Policy or Claim #:	Group # / Policy Holders Employer:
Policy Holder Name:	Date of Birth:	Social Security #
Insurance Company or Attorney Telephone #:	Policy Holders Work Phone #:	**Patient Relationship to Policy Holder:** ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Employer Information

Employer Name:	Employer Phone #:	Employment Status: ☐ None ☐ FT ☐ PT ☐ Self-Emp. ☐ Retired ☐ Student	
Address:	City	State:	Zip Code:

Emergency Contact Information

Contact Name:	Phone #	Relationship to Patient: ☐ Parent ☐ Spouse ☐ Sibling ☐ Other

Physician Information

Name of Referring Physician:	Telephone #:		
Address (Only required if new referring Physician:	City	State:	Zip Code:

I __________________________________authorize Kessler Rehabilitation to treat me as per my doctor’s prescription and to release to my Insurance company / Lawyer / Employer any information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating claims for benefits.

Date: _________________ Time: _____________________ **Signature**: ____

PLEASE PROVIDE YOUR INSURANCE CARD TO COPY AND DRIVER’S LICENSE TO REVIEW Viewed ID ☐ REVISED 9/2016