OUTPATIENT REHAB ADMISSION

MASONIC HOMES of KENTUCKY

Patient Information

Patient Name: _____ SS #: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Date of Birth: _____ Sex: _____

Referring Physician's Name: _____

Status: Single ❒ Married ❒ Divorced ❒ Widowed ❒ Separated ❒ Unknown ❒

Were you ever treated for outpatient physical therapy before? Yes ❒ No ❒

Date of Injury/Onset Date: _____ Auto Related: (Check if yes) ❒ Work Related: (Check if yes) ❒

Adjustor Name & Telephone (if injury is work or auto related): _____

_____

If Workers Comp, was accident with present employer? (Check if yes) ❒

If no, who was employer? _____

Occupation: _____

If auto accident, date of accident: _____

Type of Accident: Driver ❒ Passenger ❒ Pedestrian ❒ Job ❒ Fall ❒ Other ❒

Medicare Patients

Do you have Medicare? (Check if yes) ❒

Are you currently receiving home health services? (Check if yes) ❒

If yes, name of agency and type of home health services you are receiving: _____

If no, have you received services in past 60 days? _____

If yes, name of agency and last date of service: _____

Primary Insurance Information

Name of Insurance Company: _____ Policy or Claim #: _____

Group #/Policyholder's Employer: _____ Policyholder's Name: _____

Date of Birth: _____ Social Security #: _____

Insurance Company Telephone #: _____ Policyholder's Work Phone #: _____

Patient Relationship to Policyholder: Self ❒ Spouse ❒ Dependent ❒ Other ❒

MASONIC HOMES of KENTUCKY

Secondary Insurance Information (for automobile accidents/workers compensation/litigation)

Name of Insurance Company: _____ Policy or Claim #: _____

Group #/Policyholder's Employer: _____ Policyholder's Name: _____

Date of Birth: _____ Social Security #: _____

Insurance Company Telephone #: _____ Policyholder's Work Phone #: _____

Patient Relationship to Policyholder: Self ❒ Spouse ❒ Dependent ❒ Other ❒

Employer Information

Employer Name: _____

Employment Status: None ❒ Student ❒ FT ❒ PT ❒ Self-Employed ❒ Retired ❒

Employer Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact Information

Contact Name: _____ Phone # _____

Relationship to Patient: Parent ❒ Spouse ❒ Sibling ❒ Other ❒

Attorney Information (for litigation cases only)

Attorney Name: _____ Phone # _____

Address: _____ City: _____ State: _____ Zip: _____

Consent to Treat

I, _____, hereby consent to medical care and treatment as deemed necessary and proper by the appropriate Masonic Homes of Kentucky personnel and agree 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. I fully understand that I am financially responsible for any services not covered by this authorization.

Signature _____ Date _____
(Parent or legal guardian must sign if patient is under 18 years of age)

If you would like to receive MHKY news, announcements and healthy tips, please include your e-mail address:

_____ *(Your e-mail address will not be shared)*