OUTPATIENT REHAB ADMISSION

MASONIC HOMES KENTUCKY

Patient Information

Patient name: _____ SSN: _____

Address: _____

City: _____ ST: _____ Zip: _____

Phone: _____ DOB: _____ 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): ☐

Adjuster name and phone number (if injury is auto or work 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: _____

DOB: _____ SSN: _____

Insurance company phone: _____

Policyholder's work phone: _____

Patient relationship to policyholder: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Secondary Insurance Information

Name of insurance company: _____ Policy or claim #: _____

Group #/ Policyholder's employer: _____

Policyholder's name: _____

DOB: _____ SSN: _____

Insurance company phone: _____

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: _____ ST: _____ Zip: _____

Emergency Contact

Contact name: _____

Contact phone: _____

Relationship: ☐ Parent ☐ Spouse ☐ Sibling ☐ Other

Attorney Contact **(for litigation purposes only)**

Attorney name: _____ Phone: _____

Address: _____

City: _____ ST: _____ Zip: _____

Consent to treat

I, _____ , hereby consent to medical care and treatment as deemed necessary and proper by the appropriate Masonic Homes 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 Masonic Homes Kentucky news, announcements and healthy tips, please include your e-mail address: _____

(Your e-mail address will not be shared)