Kessler Institute for Rehabilitation Pt Intake Form

Office Use Only

Intake Date: Rec By:	**History #** **M R #** **Hospital Name:** **Past Patient:** ☐**Y** ☐**N**	IP Case Manager: IP to OP D/C Date:

Diagnosis 1 (Desc/ICD9):	Diagnosis 2 (Desc/ICD9):	Date of surgery/Injury/Onset: Do you use a WC? ☐ **Y** ☐ **N**	☐ PT ☐OT ☐ ST ☐ CRP ☐ Other

Patient Information

Patient Name: (First, MI, Last, - Sr., Jr., etc)	SS #: - -

Address:	City	State:	Zip Code:

Telephone: Alt Tele #:	Date of Birth (mm-dd-yyyy)	Sex: ☐ M ☐ ☐ F	Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Unknown

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? ☐ Yes ☐ No If No, who was employer? Occupation: ______________________________	If Auto Accident: Date of Accident: Type of Accident: ☐ Driver ☐ Passenger ☐ Pedestrian ☐ ob ☐ Fall ☐ Other

Do you have Medicare? ☐ **No** ☐ **Yes** **Do you have NJ Medicaid?** ☐ **Yes package A, B, C or D?** ☐ **No**

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 ☐ Yes ☐ No Last date of service**:**

Were you ever treated for Out Patient Physical Therapy before? ☐ No ☐ Yes Was it the same diagnosis? ☐ Yes ☐ No

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

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

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:	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

Employer Information – Required for all WC patients

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:	City	State:	Zip Code:

Office only

Services: ☐ **PT** ☐**OT** ☐**ST** ☐**CRP** ☐**Other**	Schedule: IE date / time: ☐**M** ☐**TU** ☐**W** ☐**TH** ☐**F**	**Therapist:** ___ ____________________ **Comments / Level**

I acknowledge that the above information is correct. Date: _______________ **Signature:** ______________________________

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

____ ***(Your email address will not be shared)***