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:

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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)***

PLEASE PROVIDE YOUR INSURANCE CARD TO COPY AND DRIVER'S LICENSE TO REVIEW

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