ReVive
HEALTH CENTER

New Patient Intake Form

Patient Information:

Name:_____Date of birth:_____Gender: M F

Address:_____City:_____State:_____

Zip code:_____Home phone:_____Cell phone:_____

Email:_____Social Security #:_____

Marital status:_____ Spouse's name:_____

Children's names:_____

Emergency Contact:_____Phone:_____

Employment information:

Occupation:_____Employer:_____

Business phone:_____Employer address:_____

Are you presently working? _____

Whom may we thank for referring you?_____

Workman's Compensation (leave blank if not work comp)

Employers name _____Phone:_____Occupation_____

Address_____City_____State_____Zip_____

Claims Adjustor Name _____Phone:_____Claim #:_____

Claim Adjustor Insurance Company Name:_____

Rehab Nurse Name:_____Phone#:_____Fax#:_____

Nurse Case Mgmt Co Name:_____Phone:_____Fax:_____

Personal Injury (leave blank if not personal injury)

Car Company:_____Claims manager:_____

Address:_____City:_____State:_____Zip:_____

Phone:_____Claim #:_____

ReVIVE HEALTH CENTRE FINANCIAL POLICY

- Patients with health insurance should remember that services rendered are charged to you, the patient, not your insurance company.
- As a courtesy to our patients, we will verify your insurance coverage and benefits (*Verification is only a quote) as well as file therapy claims for you, however we do not accept the responsibility for settling the claim with your carrier.
- If payment is delayed, reduced or denied, you will be responsible for settling your balance with us.
- We require 24-HOUR NOTICE for any cancellation. A fee will be charged to your account for failure to comply.

TREATMENT AUTHORIZATION

Your signature is required below to authorize treatment. Your signature also authorizes the release of medical information needed to process your claim, allowing an assignment of benefits where a claim has been filed, and acknowledging your understanding of the above office policies. An additional treatment authorization signature is required by a parent / legal guardian for all minors.

_____

Patient Signature Date

_____

Parent or Guardian Signature / Print Full Name Date

HIPAA AUTHORIZATION

In compliance with HIPAA regulations, I authorize the following individuals to receive verbal information regarding the billing of my account.

_____	_____	_____
Name / Relationship	Name / Relationship	Name / Relationship

Previous Medical History (Check if you have had or have any of the following):

- o Chest pain or discomfort
- o Heart palpitations
- o Heart murmur
- o Kidney disease
- o Back pain
- o Neck pain
- o Coronary artery disease
- o Hypertension
- o Peripheral vascular disease
- o Asthma
- o Bronchitis
- o Emphysema
- o COPD
- o Acid reflux
- o Ulcerative colitis
- o Diverticulis
- o Hyperlipidemia
- o High cholesterol
- o Thyroid disorder
- o Diabetes
- o Gout
- o Migraines
- o Stroke
- o Depression
- o Anxiety
- o Sleep apnea
- o Carpal tunnel
- o Rotator cuff syndrome/tear
- o Tennis or Golfer's elbow
- o Hip/knee pain
- o Plantar fasciitis

Others not listed: _____

_____

_____

Please list all surgeries: _____

_____

_____

_____

Please list all medications (prescriptions, over-the-counter, supplements):_____

_____

_____

_____

_____

Please list your trauma history (sports injuries, trips, falls, car accidents): _____

_____

_____

_____

_____