WE RELIEVE YOUR PAIN!

Physical Therapy – Occupational Therapy – Speech Therapy

- **DADE:** 16459 NE 6th Ave North Miami Beach, FL 33162
  Office: 305.949.5499 ◊ **Fax:** 305.949.5461
- **BROWARD:** 660 N. State Rd 7, Suite 14 Plantation, FL 33317
  Office: 954.990.5692 ◊ **Fax:** 305.949.5461

www.MercyOutpatientClinic.com

Patient Intake Form

NAME: _____
FIRST MIDDLE LAST

DATE OF BIRTH: __/___/____ Age _____ SOC. SEC. NUMBER: _____

ADDRESS: _____
STREET CITY STATE ZIP

PHONE: HOME ( ) _____ WORK ( ) _____ CELL ( ) _____

PATIENT IS: MARRIED ☐ SINGLE ☐ WIDOWED ☐ SEPARATED ☐ DIVORECED☐ MINOR☐
MALE ☐ FEMALE ☐ HIGHT _____ WEIGHT _____

EMAIL: _____ PREFERRED WAY TO CONTACT: HOME ☐ WORK☐ CELL☐

REFERRING PHYSICIAN: _____ _____ PHONE: _____

PRIMARY CARE PHYSICIAN: _____ _____ PHONE: _____

EMPLOYER or SCHOOL NAME_____ _____ PHONE: _____

EMERGENCY CONTACT NAME: _____ PHONE: _____
RELATION _____ _____ ADRESS: _____

RESPONSIBLE PARTY INFORMATION

RELATION TO PATIENT: MOTHER ☐ FATHER ☐ OTHER ☐

NAME: _____ SOC. SEC. NUMBER: _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET CITY STATE ZIP

HOME PHONE ( ) _____ WORK ( ) _____ CELL ( ) _____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: _____ INSURED NAME: _____
POLICY ID# _____ POLICY GROUP # _____
PHONE # _____ Co-Pay Amount: _____ Deductible Met: Yes ☐ No ☐

SECONDARY INSURANCE NAME: _____ INSURED NAME: _____
POLICY ID# _____ POLICY GROUP # _____
PHONE # _____ Co-Pay Amount: _____ Deductible Met: Yes ☐ No ☐

Have you received therapy from any agency including home health? Yes☐ No☐
0-6 months ago☐ 7-12 months ago☐ more than 12 months ago☐

Have you been injured in an auto accident, slip and fall, or work related injury?
Yes ☐ No ☐

Do you have any type of claim pending with an insurance company or suit that has not been settled with an attorney?
Yes ☐ No ☐

Have you been referred to this practice resulting in any way from this accident?
Yes ☐ No ☐

Date of Accident: _____ **Motor Vehicle**☐ **Work Related**☐ **Slip/Fall**☐ **Other** ☐

How did you hear about us? _____

If referred by a friend, please give us their name so we can thank them properly.
Name: _____ **Phone #** _____

I pledge that the answers given are honest and truthful to the best of my knowledge.

HIPAA: By signing this form I acknowledge that I have received a copy of the HIPAA "Notice of Information Practices" from Mercy Outpatient Rehabilitation Clinic and understand it completely.

CONSENT: By signing this form, I agree and give my consent for Mercy Outpatient Rehabilitation Clinic to furnish physical therapy care and treatment considered necessary and proper in diagnosing and/or treating my physical condition.

Patient Signature _____ Date_____
Please complete this form in its entirety. Also, please bring your insurance information and/or cards to our office at your first visit. It is the patient's responsibility to notify our office of any changes to your information listed on this form.