H.P.T Internal Case Management

Returning Patient [ ]

Referral Written: _____/_____/_____ **Rx/Referral Received:** _____/_____/_____ **Initial Visit:** _____/_____/_____

First Name: _____ **Mi:** _____ **Last:** _____ **Date of Birth:** _____/_____/_____

Street: _____ **Home #:** (_____) _____

City: _____ **State:** _____ **Zip Code:** _____ **Work #:** (_____) _____

Email Address: _____ **Cell # :** (_____) _____

Sex: [ ] F [ ] M **Social Security #:** _____-_____-_____ **Drivers License #:** _____ **State:** _____

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated

HOW DID YOU HEAR ABOUT US? *[ ] Physician [ ] Yellow Pages [ ] Friend /Relative [ ] Insurance Company [ ] OTHER:* _____

Do you currently receive any MEDICAL assistance at Home? [ ] YES [ ] NO

EMPLOYER INFORMATION

Employer/School: _____ **Contact Person (e.g. supervisor)** _____

Phone: (_____) _____ **Job Title/Occupation:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Employed: [ ] Full Time [ ] Part Time [ ] Student [ ] Other _____ [ ] CURRENTLY WORKING _____ [ ] NOT WORKING

POLICY HOLDER INFORMATION /PARENT OR LEGAL GUARDIAN INFORMATION if patient is a minor

Name: _____ **SS #:** _____-_____-_____ **Date of Birth:** _____/_____/_____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone #: (_____) _____ **Relationship:** _____ **Employer:** _____

EMERGENCY INFORMATION

Emergency Contact: _____ **Primary Language:** _____

Emergency Phone #: (_____) _____ **Relationship:** _____

REFERRING PHYSICIAN INFORMATION

Name: _____ **Phone #:** (_____) _____ **Fax #** (_____) _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

RX FREQUENCY / DURATION: _____ **DIAGNOSIS:** _____

BODY PART: _____ **D.O.I** _____ **DATE OF SURGERY** _____

INSURANCE INFORMATION - (Please provide card)

[ ] WORK COMP [ ] PRIVATE INS [ ] HMO [ ] MEDICARE [ ] MEDICARE /M-CAL [ ] AUTO ACCIDENT [ ] NO COVERAGE

Payor: _____ **Address:** _____

City: _____ **State:** _____ **Zip:** _____ **Phone #:** _____

Group #: _____ **Id #:** _____

Adjuster: _____ **Phone #:** (_____) _____ **Fax #** (_____) _____

Claim #: _____

Case Manager: _____ **Phone #:** (_____) _____ **Fax #** (_____) _____

SECONDARY INSURANCE – (Please provide card)

Payor: _____ **Phone #:** (_____) _____ (_____) _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Group #: _____ **Id #:** _____