Oncology Rehabilitation Specialists, Inc. 1239 120th Ave NE, Suite E, Bellevue, WA 98005 (425) 467-7105

PATIENT INTAKE REGISTRATION FORM

PATIENT INFORMATION

Patient Name:_____
Last, First, M.I.

Gender: M or F Birth Date: _____/_____/_____ Age:____ Soc. Sec# _____-____-_____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Primary phone: (_____) _____-_____ Secondary phone: (_____) _____-_____

Email: _____ Can we email appointment reminders? Y N

Referring Physician: _____Phone: (_____) _____-_____

Primary Care Provider: _____Phone: (_____) _____-_____

Please list the name of someone you authorize us to contact in case of an emergency. Please note that notifying this person may require us to reveal medical information about you:

Emergency Contact Name: _____ Phone: (____) _____-_____

Is there anyone else you would like to specify we can share your medical information with?
Circle one: Yes No If yes, please indicate their name(s) below:
_____

Is there anyone that you specifically DO NOT wish us to share your medical information with?
Circle one: Yes No If yes, please indicate their name(s) below:
_____

Have you received any physical or speech therapy, home therapy or pool therapy for any condition this year?
Circle one: Yes No If yes, please indicate the condition and the duration of care below:
_____

Are you currently receiving any kind of home health care, including physical therapy, occupational therapy, speech therapy, respiratory therapy or nursing care?
Circle one: Yes No If yes, please indicate which type of care and the providing agency below:
_____

_ _

FOLLOWING SECTIONS ARE FOR OFFICE USE ONLY:

INSURANCE VERIFICATION:

Date of Verification: _____ **By Whom:** _____

Benefits Active as of: _____ **Plan Name:** _____

Deductible amount: _____ **Deduct. met this year:** _____

Co-Pay amount: _____ **Benefit Limit/Met:** _____

% of allowed amount covered: _____ **% of Co-insurance:** _____