# ***The Summit Outpatient Clinic * Patient Information Sheet***

**Prescription Date:** ______________________ **Discipline:** ☐ OT ☐ PT ☐ ST
**Physician's Name:** ______________________ **Has patient recently had SURGERY?** ☐ Y ☐ N
**Phone:** ______________________ **Surgery Date:**______________

## PATIENT INFO

**Patient's Name:** ______________________ **DOB:** ______________ **Age:** ________
**Mailing Address:** ______________________ **Home Ph:** ______________ **Cell:** ________
**City, State and Zip:** ______________________ **SS # :** ______________ **U.S. Citizen:** ☐ Y ☐ N
**Marital Status**: ☐ Juvenile ☐ Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed **Gender:** ☐ Male ☐ Female
**Patient's Employer:** ______________________ **Work Ph:** ______________
**Responsible Party:** ______________________ **Phone:** ______________ **Relation:** ________
**Emergency Contact:** ______________________ **Contact Ph:** ______________ **Relation:** ________

## INSURANCE INFO

****** Copy of Insurance Card & I.D. is needed******

**Primary Ins:** ______________________ **ID # :** ______________ **Group # :** ________
**Policy Holders Name:** ______________________ **DOB:** ______________
**Employer:** ______________________ **SS# :** ______________

**Secondary Ins:** ______________________ **ID # :** ______________ **Group # :** ________
**Policy Holders Name:** ______________________ **DOB:** ______________
**Employer:** ______________________ **SS# :** ______________

**Workman's Comp:** ______________________ **Claim # :** ______________
**Contact/Adjuster:** ______________________ **Ph:** ______________
**Employer:** ______________________ **Date of Injury:** ______________

**Home Health:** **Is patient *currently* receiving HHC?** ☐ Y ☐ N **How Long?** ______________
**Home Health Facility:** ______________________ **D/C Date:** ______________

**Medicare # :** ______________________ **Active Coverage:** ☐ YES ☐ NO
**Medicaid # :** ______________________ **Active Coverage:** ☐ YES ☐ NO

****** If Medicaid, there is no coverage for therapy over the age of 18******

## PATIENT HISTORY

**Was your injury the result of an accident?** ☐ **Yes** ☐ **No** **Was it employment Related?** ☐ **Yes** ☐ **No**
**If so, what was the date of injury?** ______________
**List any surgeries (along with dates) that you have had:** ______________________

______________________

______________________

**List any medications that you are taking:** ______________________

______________________

**Have you or a family member ever had any of the following?**
☐Diabetes ☐ Heart Disease ☐ High Blood Pressure
☐ Cancer ☐ Other ______________

**Patient / Parent or Guardian Signature:** ______________________ **Date:** ______________
**For "X" Signature:** **Witness (1):** ______________________ **Witness (2):** ______________