

MILLENNIUM REHABILITATION - A Physical Therapy and Sports Medicine Center

PATIENT NAME: _____	DATE OF BIRTH: _____
ADDRESS: _____	SOCIAL SECURITY # _____
CITY, STATE, ZIP: _____	SEX: F M MARITAL STATUS: S M W D
HOME PHONE: _____	2 ND PHONE # _____
EMAIL: _____	

Referring Physician (name and phone #): _____			
Diagnosis: _____	Date of Surgery: _____		
ICD-9 : 1. _____	2. _____	3. _____	4. _____
Primary Care Physician (name and phone #): _____			

PRIMARY INSURANCE: _____
INSURED'S NAME: _____
S.S.# _____ D.O.B. _____
ADDRESS: _____
CITY , STATE, ZIP: _____
PHONE #: _____
INSURANCE PH #: _____
INSURANCE ADDRESS: _____

SECONDARY INSURANCE: _____
INSURED'S NAME: _____
S.S.# _____ D.O.B. _____
ADDRESS: _____
CITY, STATE, ZIP: _____
PHONE #: _____
INSURANCE PH #: _____
INSURANCE ADDRESS: _____

Emergency Contact (name, phone, relationship): _____
How were you referred to Millennium Rehabilitation? <input type="checkbox"/> Previous Patient <input type="checkbox"/> High School <input type="checkbox"/> Newspaper <input type="checkbox"/> Internet Search <input type="checkbox"/> Other
Please specify: _____
Would you like to receive information & updates from Millennium Rehabilitation via email or text message? YES NO
MEDICARE/MEDICAID PATIENTS ONLY: Are you currently receiving home-health care? YES (name _____) NO
Have you had Chiropractic, Occupational, or Physical Therapy this year? _____ If so, how many visits? _____
Is this condition a result of an accident or injury? YES NO If so, date and location and how injury occurred: _____

I give my consent to treatment, authorize the release of necessary information to all of my insurance carriers, and that my insurance carriers are to pay MILLENNIUM REHABILITATION, LLC, directly for services rendered. I understand that I am financially responsible for any/all services rendered.

Signature: _____ Date: _____

After 2 "no shows" or 2 cancellations without a 24 hour notice, a \$50 fee will be assessed to your account for each additional "no show" or cancelled appointment.

Signature: _____ Date: _____