COVENANT THERAPY CENTERS – NEW PATIENT ***STICKER HERE***

To be used for Downtime

PATIENT INFORMATION

Name ____________________ SS#____________________

Birthdate ____________________ Marital Status ____________________ Gender____________________

Address ____________________ City____________________ State ______ Zip__________

Home Phone____________________ Cell Phone____________________ Work Phone ____________________

Email Address ____________________ Employer ____________________

Emp Address ____________________ City____________________ State ______ Zip__________

Employment ❑ Full-time ❑ Part-time ❑ Unemployed ❑ Self Employed ❑ Retired (date) __________

GUARANTOR* (NAME OF INSURED IF DIFFERENT THAN PATIENT) * If same as patient, please skip this section

Name____________________ Relationship to patient____________________

Birthdate ____________________ Home Phone ____________________ SS# ____________________

Employer ____________________

PHYSICIAN / EMERGENCY CONTACT

Referring Physician ____________________

Primary Care / Family Physician ____________________

Emergency Contact Name ____________________ Relationship to Patient ____________

Home Phone ____________________ Work Phone ____________________

MEDICARE PATIENTS ONLY:

Is your Medicare based on: ❑ **Age** ❑ **Disability** ❑ **ESRD** **Effective Date ______________**	**YES**	**NO**
Are you currently receiving any treatment from Home Health?		
Do you receive Dialysis?		
Has the Department of VA authorized and agreed to pay for your care at this facility?		
Do you receive Black Lung Benefits		
Are your services to be paid by a government research program?		
Have you had a kidney transplant?		

ACCIDENT INFORMATION *If not due to an accident, please skip this section

Type of accident? ❑ Auto ❑ Work-related ❑ Other Accident Date __________ Time__________ State ______

Auto Insurance Company____________________ Phone ____________________

Auto Insurance Address ____________________ City ______________ State ______ Zip __________

Case Manager/Adjustor Name____________________ Phone ____________________

COVENANT THERAPY CENTERS – HEALTH INFORMATION *STICKER HERE*

PAST MEDICAL HISTORY – Have you ever been diagnosed with any of the following?						
	YES	**NO**			**YES**	**NO**
High blood pressure				Pregnant (currently)		
Any heart problems				Asthma		
Do you have a pacemaker				Bronchitis		
Stroke				Emphysema		
Cancer				Kidney disease		
Lung disease				Liver disease		
Seizures				Latex allergy		
Diabetes				Do you smoke		
Low blood sugar				Feel faint or have spells of severe dizziness		

Complaint/Diagnosis ____ Onset Date ______________________

Adverse and Allergic Drug Reactions: ❑ See Attached Medication List

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Medications (including Prescriptions, Herbals and Over-the-Counters Drugs): ❑ See Attached Medication List

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

SHARING YOUR INFORMATION

In the event our office needs to contact you regarding your appointment, etc.

I give permission to be contacted by phone/text and for messages to be left at this number

❑ Yes (❑ Cell ❑ Home ❑ Work) ❑ No

I give permission to have letters, documents and postcards sent to my home and/or email address

❑ Yes ❑ No

ACKNOWLEDGEMENT OF PRIVACY – OPEN GYM ATMOSPHERE:

I understand that my treatment may be provided in an open gym atmosphere and agree to request private treatment or conference area if needed.

WITNESS: ______________________________ **SIGNED:** ______________________________

(Patient or Representative)

DATE: ______________________________ **BY:** ______________________________

TIME: ___________________________ **AM / PM** **RELATIONSHIP TO PATIENT:** ______________________