COVENANT HEALTH THERAPY CENTERS – NEW PATIENT

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 _____