

# REHAB RESOURCES OF SHEBOYGAN SERVICES

## PATIENT INTAKE FORM

Date of Referral: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Script: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ Zip: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Parent Name(s) \_\_\_\_\_

Physician: \_\_\_\_\_

Therapy Needs

Comments

Physical Therapy ( ) \_\_\_\_\_

Occupational Therapy ( ) \_\_\_\_\_

Language/Speech Therapy ( ) \_\_\_\_\_

### INSURANCE INFORMATION

Insurance Company Name: \_\_\_\_\_

Subscriber ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Claims Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber Birth Date: \_\_\_\_\_

Medical Assistance #: \_\_\_\_\_

HMO: \_\_\_\_\_

(To save time during the initial visit, this form can be printed on your computer, completed and submitted to the receptionist.)