CENTER FOR ORTHOPEDIC REHABILITATION
CORE
Quality at the CORE

Patient Demographics

Is the injury related to an auto accident? YES _____ NO _____
Work injury? YES_____ NO _____
Other? YES_____ NO_____
If so, what was your injury date? _____
Injury location_____
Who referred you? _____

Patient Information

Name Last	First		MI
Other Name	Social Security #	Date of Birth	
Street Address	City	State	Zip
Home Phone #	Cell phone #	Sex [ ] Male [ ] Female	
Email Address (if applicable)			
Primary Care Physician (PCP)		Marital Status [ ]Single [ ] Married [ ]Other	
Employer Name		Employer Phone #	
Employer Address	City	State	Zip

Responsible Party Information (complete ONLY if NOT patient)

Name		Relationship to Patient [ ] Self [ ] Spouse [ ] Dependent	
Street Address	City	State	Zip
Home Phone #	Employer Name		
Work Phone #	Employer Address		

Primary Insurance Information

Insurance Company Name		Insurance Company Phone #	
Street Address	City	State	Zip
Member ID #	Group #	Date Policy Became Effective	
Patients Relationship to Subscriber [ ] Self [ ] Spouse [ ] Dependent		Subscriber Social Security #	
Subscriber Name		Subscriber Date of Birth	
Subscriber Address		Subscriber Employer	

Secondary Insurance Information

Insurance Company Name		Insurance Company Phone #	
Street Address	City	State	Zip
Member ID #	Group #	Date Policy Became Effective	
Patients Relationship to Subscriber [ ] Self [ ] Spouse [ ] Dependent		Subscriber Social Security #	
Subscriber Name		Subscriber Date of Birth	
Subscriber Address		Subscriber Employer	

Emergency Contact Information

Emergency Contact Name	Relationship	Home Phone #	Work/Cell #

Assignment of Benefits

Authorization to pay benefits to physician: I hereby authorize payment directly to the undersigned Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for services as described.

Authorization to release information: I hereby authorize the undersigned Physician to release any information acquired in the course of my examination or treatment to the insurance company or any other party involved in the reimbursement claim.

X_____

Signature of Patient or Legal Guardian Date

For MEDICARE Patients ONLY
Lifetime Assignment of Medicare Benefits

I request that payment of authorized Medicare benefits be made to me or on my behalf to the above referenced Medical Practice for services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its agents any information needed to determine these benefits or the benefits payable for related services.

X_____

Signature of Patient or Legal Guardian Date

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Medical History Questionnaire

Name_____ Age _____

Date of Birth _____ Height _____ Weight _____

Chief Complaint _____

Date of Onset/ injury _____

How did this injury occur? _____

_____

List any allergies to medications or food _____

_____

List any skin allergies (tape, sutures, betadine, latex) _____

Are you taking Coumadin? Yes _____ NO _____

Do you smoke cigarettes? Yes_____ No _____ How long have you smoked for and how much? _____

Do you drink alcohol? Yes _____ No _____ How long have you drank and how much? _____

DO YOU HAVE A HEART CONDITION? YES _____ NO _____

Are you being treated for HEART, LUNG OR PULMONARY PROBLEMS? YES _____ NO _____

Please explain condition and treatment _____

Are you seeing or have you seen a cardiologist or pulmonary doctor? Yes _____ No _____

Please explain reason for visit _____

Please circle if you have any of the following conditions:

Anemia	Chest Pain	Heart Attacks	Palpitations
Aneurysms	Chronic Leg Ulcers	Hepatitis	Phlebitis
Artery Conditions	Cardiac Stents	High Blood Pressure	Rheumatoid Arthritis
Asthma	Deep Vein Thrombosis	Immune Deficiency	Scoliosis
Bladder Disease	Diabetes	Kidney Disease	Seizure Disorders
Blood Disorder	Emphysema	Leukemia	Stomach Problems
Cancer	Epilepsy	Lung Disease	Stroke
Type _____	Gout	Osteoarthritis	TB

Any other conditions not mentioned above? _____

Do any members of your family have a history of the above? _____

_____

Previous surgery dates _____

Any complications with surgeries or anesthesia? _____

I, the undersigned, have reviewed the above questions and have answered this information to the best of my knowledge. I believe these answers to be true, correct, and complete.

X_____ Date: _____

Signature of Patient or Guardian

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MEDICATIONS

Medication	Dosage	Frequency

*If you have a list of medications already written up please make a copy and attach it to packet. Thank you.

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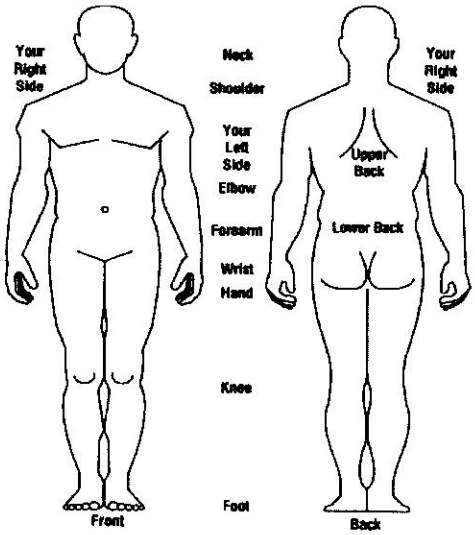
PAIN QUESTIONNAIRE PT

PATIENT NAME: _____ Date: _____

On the drawings below, please indicate where you are experiencing pain.



On a scale from 0-10, please indicate your pain level. 0 means no pain and 10 means the worst pain imaginable.

Pain at worst: _____ Pain at best: _____ Average pain: _____

Functional Status: Please rate the following tasks by how much pain or difficulty you have doing them.

Example: If you sometimes have pain getting in and out of bed, circle 2 for sometimes.

Never = 1 Sometimes = 2 Frequently = 3 Constantly = 4

1. Getting in/out of bed	1	2	3	4	9. Bathing	1	2	3	4
2. Getting in/out of a chair	1	2	3	4	10. Toileting	1	2	3	4
3. Walk through home/stairs	1	2	3	4	11. Reaching	1	2	3	4
4. Walk in community	1	2	3	4	12. Housekeeping	1	2	3	4
5. Walk on uneven surfaces	1	2	3	4	13. Carrying packages	1	2	3	4
6. Prolonged standing	1	2	3	4	14. Work activities	1	2	3	4
7. Prolonged sitting	1	2	3	4	15. Computer activities	1	2	3	4
8. Dressing	1	2	3	4	16. Leisure activities	1	2	3	4

If sitting or walking is difficult, please indicate how long you can do each activity at this time.

Sit: _____ Stand: _____ Walk: _____

Patient Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

CENTER FOR ORTHOPEDIC REHABILITATION, INC
315 COTUIT ROAD UNIT 1
SANDWICH, MA 02563
PH - 508-833-1460 FAX - 508-833-1462

I, _____, understand that my bill for medical services is my responsibility. I also understand that any payments made to me by my attorney or insurance company for services rendered, will be reimbursed to Center for Orthopedic Rehabilitation, Inc. upon receipt.

Health Insurance:
I understand that it is my responsibility to understand the terms of my insurance coverage. If my insurance coverage requires prior authorization, as well as approvals for a limited number of visits, it is my responsibility to keep track of the number of visits, It is also my responsibility to obtain physician referrals when applicable. (Please note: if you exceed the number of approved visits by your insurance company, said company may deny responsibility for payment, in that event, payment for those visits will become your responsibility.)

Workers Compensation:
I understand that my workers compensation claim must be approved before commencing treatment. It is my responsibility to keep track of my approved number of visits. In the event that my insurer should deny my claim, I understand that I will be responsible for any services rendered.

I understand that Center for Orthopedic Rehabilitation, Inc. will submit my claims to my insurance company for reimbursement. In the event that my insurance company has not paid my claim within 45 days, I agree to pay Center for Orthopedic Rehabilitation, Inc. within 30 days of notification and to seek reimbursement from the appropriate party. I understand that I will be billed personally, for all allowable deductibles, co-insurance, missed appointments and insurance denials.

I have read the above information and I understand that treatments/expenses incurred on my behalf are, ultimately, my responsibility.

_____
(signature)

_____
(date)