



**PLEASE READ, FILL OUT AND SIGN THE PATIENT/CLIENT INFORMATION FORM**

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Email address:** \_\_\_\_\_ @ \_\_\_\_\_ . \_\_\_\_\_

**Social Security Number** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ / \_\_\_\_\_

(NAME)

(Phone number)

**List any additional person(s) that can have access to your medical records:**

**Name:** \_\_\_\_\_ **Name:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Name:** \_\_\_\_\_

**Other services THIS YEAR: (needed due to insurance limitations)**

- Are you in Home Health now? [ ] yes [ ] no (**IF ANSWERED YES PLEASE SEE FRONT DESK** )
- Are you currently in Physical or Occupational Therapy? [ ] yes [ ] no

**List below or bring a list of your medicines, medical conditions currently being treated and surgical history.**

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In order to provide the best care, we may need to Correspond with other Doctors or Medical Providers. By listing your providers and signing below, you are giving Cares Health and Wellness permission to communicate with them. At any time if this changes please notify the front office.

Primary Care Physician: \_\_\_\_\_

Cardiologist: \_\_\_\_\_ Pulmonologist: \_\_\_\_\_

Oncologist: Medical: \_\_\_\_\_

Radiation: \_\_\_\_\_

Surgeon: \_\_\_\_\_

Orthopedic: \_\_\_\_\_

OTHER: \_\_\_\_\_

### CONSENT TO PHOTOGRAPH

I hereby **give my consent** for the area being treated to be photographed (including video photography) for medical documentation and insurance justification.

**YES OR NO**

- At times, your physician or your therapist may feel that there is procedure, supply or piece of equipment that is medically necessary that your individual policy may or may not cover. You have the right not to receive items that we know *in advance* are not covered by your insurance. If for some reason a non-covered fee is incurred, *the patient will be responsible for the full amount*. We will try every possible attempt to notify you of this fee in advance.

- By signing below in case of an Emergency, you are giving us permission to give a copy of your information to the appropriate medical staff.

\_\_\_\_\_ (PRINT NAME)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date