

Elmwood Orthopedic Rehab Center, Inc.

193 Elmwood Avenue

Providence, RI 02907

Tele: 401.459.4000 Fax: 401.459.4005

Patient Intake Form

Intake Date: _____ Interviewer: _____

BASIC PATIENT INFORMATION

Circle One: Driver Passenger Bicycle Pedestrian Motorcycle MBTA
Back Front

First Name: _____ Last Name: _____ M / F

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone/Pager: _____ Date of Birth: _____

Social Security No: _____ License: _____

Marital Status: **Single** **Married** **Divorce**

EMPLOYMENT INFORMATION

Employer Name: _____

Occupation: _____ Tele #: _____

Are you missing time from work? **YES** **NO** (circle one)

How long? _____

AUTOMOBILE INFORMATION

Date of Accident: _____ Time of Accident: _____ **AM/PM**

Location of Accident: _____

Name & Address (Driver): _____

Name & Address (Owner): _____

Year/Make/Model: _____ License Plate #: _____

Insurance Company Name: _____

Claim Number: _____ Adjustor: _____

ATTORNEY INFORMATION

Name: _____

Address: _____

Telephone #: _____ Contact: _____

HEALTH INSURANCE INFORMATION

Do you have Health Insurance? **YES** **NO** (circle one)

Name of Health Insurance Carrier: _____

Subscriber: _____ Card No: _____

Group No: _____ Exp. Date: _____

OTHER VEHICLE (BI) INFORMATION

Driver's Name: _____

Address: _____ Tele #: _____

License: _____ Date of Birth: _____

Owner of vehicle: _____

Address: _____ Tele #: _____

Year/Make/Model: _____ License Plate: _____

Insurance Company Name: _____

Claim Number: _____ Adjustor: _____

HOUSEHOLD VEHICLE INFORMATION

Does patient own an Insured/Registered Vehicle? **YES** **NO** (circle one)

If yes, who is the Insurance Carrier? _____

Does anyone living in the Household own any vehicles? **YES** **NO** (circle one)

If yes, who is the Policy Holder? _____

Insurance Carrier Name: _____

Did Police come to the scene: **YES** **NO** (circle one)

Was patient removed from the scene by ambulance? **YES** **NO** (circle one)

Was patient taken to Hospital? **YES** **NO** (circle one)

Name of Hospital: _____ Date of visit: _____

What are your major complaints: _____

DESCRIPTION OF ACCIDENT

Brief description of accident, please write below:

I understand and agree that Health and Accident Insurance policies are an arrangement between the insurance carrier and myself. I authorize payment from my Insurance Carrier directly to this office with the understanding that all monies will be credited to my account upon receipt.

Patient's Name: _____ Date: _____

Patients Signature: _____