CONE HEALTH
Rehabilitation

LABEL

Name				
Address		City	State	Zip
Telephone (Home)	Telephone (Cell)	DOB	Race	Sex
Marital Status ▯ M ▯ S ▯ SEP ▯ D ▯ W	Date of Illness/Injury	SS#		
Work Status ▯ FT ▯ PT ▯ SELF ▯ UNEMP ▯ Active Military ▯ RET		Employer	Employer Telephone	
Employer Address				

OTHER INFORMATION

Accident ▯ YES ▯ NO	Type of Accident	Date of Accident	Nature of Accident
Diagnosis			
Previous OP/ED MCHS Visits (within last 24-72 hrs) ▯ YES ▯ NO ▯ UNK Where:	Primary Care Physician	Patient Restrictions	

GUARANTOR INFORMATION (Individual Responsible for Bill)

Name			Telephone	
Address		City	State	Zip
DOB	SS #	Work Status ▯ FT ▯ PT ▯ SELF ▯ UNEMP ▯ Active Military ▯ RET ▯ UNK		
Employer		Employer Telephone		
Employer Address		City	State	Zip

EMERGENCY CONTACT PERSON

Name		Address	
Telephone	Relationship to Patient	Employer	Telephone

INSURANCE INFORMATION

* ***Have you applied for Medicaid and are waiting to see if you qualify?*** ▯ Yes ▯ No

Name of Insurance Company		Policy #	Group #
Address		Telephone	Relation to Subscriber
Policy Holder Employer	Policy Holder Name	Policy Holder DOB	Policy Holder SS#:

Name of Insurance Company			Policy #		Group #
Address		City	State	Zip	Telephone
Employer	Subscriber Name		DOB		Relation to Subscriber

MEDICARE QUESTIONNAIRE

Is a Federal Government Program Responsible for this Visit? ▯ YES ▯ NO If Yes, ▯ BL ▯ FGR ▯ VA

How are you entitled to Medicare? ▯ Age ▯ Disability ▯ ESRD

Age	Disability	ESRD
Retired Date: Spouse's Retired Date: (if applicable) GHP Coverage through Current Employment ▯ YES ▯ NO 20 or more Employees ▯ YES ▯ NO	Retired Date: Family Member's Retired Date: LGHP Coverage through Current Employment ▯ YES ▯ NO 100 or more Employees ▯ YES ▯ NO	GHP Coverage ▯ YES ▯ NO If Yes, Dialysis ▯ YES ▯ NO Date: Kidney Transplant ▯YES ▯NO Date: Still in 30 month Coordination Period ▯ YES ▯ NO, If Yes, Dually Entitled ▯ YES ▯ NO (A & ESRD, D & ESRD) which was 1st ▯ A ▯ D ▯ ESRD

*****How did you hear about our clinic?** ______________________________