New Patient Intake Form

Thank you for choosing Optimum Rehab.

To help us serve you more efficiently, please read and complete each section in its entirety.
Return these completed forms via email or bring them to your first appointment.

Patient Name (Last, First, Middle Initial)	Date of Birth	Gender	
Mailing Address	City	State	Zip
Phone Number: mobile | home	Employer	Work Phone	
May we send you text reminders for your appointments? Yes | No		Social Security #	
Email	Payment Method: Insurance | Out of Pocket		
Name on Insurance Card	Insurance Provider		
Is there someone we can thank for a referral to Optimum Rehab? If yes, please list their name here:			
Emergency Contact	Phone	Relation to patient	
Primary care physician	Clinic Name		

Please initial each section as appropriate	
I have received HIPAA information	
It is okay to leave messages on my voicemail and/or speak with anyone regarding my appointments via home or work phones or voicemail	
It is NOT okay to leave messages regarding my appointments	

I authorize Optimum Rehab to provide assessment and treatment for my condition.

I assign all medical benefits to which I'm entitled to Optimum Rehab.

I realize that if my insurance (third party payer) denies my charges, or makes partial payment, I am responsible for the remaining balance.

I understand that co-payments are due at the time of service.

I authorize Optimum Rehab to release all necessary information, including medical records, for safe and effective treatment of my condition and to obtain payment.

Patient Signature: _____

Parent/Guardian Signature: Date:

What brings you to Optimum Rehab?		Date of injury/symptoms	
What is your goal for therapy?			

Have you consulted with any other providers for this complaint/concern?	☐ No	☐ Yes, explain
Have you received any testing for this complaint/concern?	☐ No	☐ Yes, explain

Have you RECENTLY experienced any of the following? (Check all that apply)		
☐ Fatigue	☐ Fever/chills/night sweats	☐ Abdominal pain
☐ Fainting	☐ Nausea/vomiting	☐ Difficulty swallowing
☐ Dizziness	☐ Heartburn/indigestion	☐ Muscle weakness
☐ Coughing/shortness of breath	☐ Headaches	☐ Pregnancy
☐ Falls/loss of balance	☐ Bleeding/bruising easily	☐ Pacemaker
☐ Skin changes	☐ Numbness/tingling	☐ Fracture/suspected fracture
☐ Infection	☐ Weight loss	☐ Other:

Have you EVER been diagnosed with any of the following? (Check all that apply)		
☐ Cancer	☐ Multiple sclerosis	☐ Hepatitis/liver disease
☐ Depression	☐ Rheumatoid arthritis	☐ Bone or joint infection
☐ Thyroid problems	☐ Osteoarthritis	☐ Asthma
☐ Heart/cardiac problems	☐ Circulation/vascular problems	☐ STD or HIV
☐ Lung problems	☐ Epilepsy	☐ Pneumonia
☐ Diabetes	☐ Blood clots	☐ Spina bifida
☐ Chest pain/angina	☐ Stroke	☐ Lupus
☐ Tuberculosis	☐ Ulcers	☐ Alcoholism
☐ Osteoporosis	☐ Bladder/urinary tract infections	☐ Drug dependency
☐ High blood pressure	☐ Anemia	☐ Fibromyalgia
☐ GERD/gastrointestinal problems	☐ Kidney disease/infection	☐ Other :

Please list any surgeries/procedures you have had. Include dates.

Please sign and date		
Patient Signature	Parent and/or Guardian Signature	Date