



Longwood Rehabilitative Services

PATIENT DATA SHEET

NAME: _____ DATE OF BIRTH _____

PHONE: (HOME) _____ (CELL) _____ (WORK) _____

ADDRESS: _____
STREET CITY STATE ZIP CODE

E-MAIL: _____ SOCIAL SECURITY NUMBER: _____ - _____ - _____

EMERGENCY CONTACT/RELATIONSHIP: _____ PHONE: _____

REFERRING PHYSICIAN: _____ NEXT DR. APPT? _____

DIAGNOSIS: _____ OCCUPATION: _____

EMPLOYER: _____

EMPLOYER ADDRESS _____
CITY STATE ZIP CODE

HOW DID YOU HEAR ABOUT LONGWOOD REHAB? _____

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for Longwood Rehabilitative Services, Inc. to furnish physical therapy/health care and treatment to _____ considered necessary and proper in diagnosing and/or treating his/her physical condition.

PATIENT/GUARDIAN: _____ DATE: _____

BENEFIT ASSIGNMENT

I, hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and all third party payors to Longwood Rehabilitative Services, Inc. I hereby authorize said assignee to release all information necessary, including Medical records, to secure payment. A photocopy of this assignment is to be considered as valid as the original.

PATIENT/GUARDIAN: _____ DATE: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing or initialing below, I confirm that I have received a copy of the Notice of Privacy Practices for Longwood Rehabilitative Services, Inc.

PATIENT/GUARDIAN: _____ DATE: _____