

Staff to complete:

Admit Date: \_\_\_\_\_

Referring Phy: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Primary Care Phy: \_\_\_\_\_

**Patient to complete:**

PATIENT NAME: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_ (Last) (First) (Middle)

CITY: \_\_\_\_\_ STATE/ZIP CODE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL/DAYTIME: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

HOW DID YOU HEAR ABOUT OUR SERVICES: \_\_\_\_\_

**Patient's Employer Information:**

EMPLOYER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Please circle: MALE FEMALE RACE (Optional): \_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_ SPOUSE'S NAME: \_\_\_\_\_

**Primary Insurance Information:**

INSURED'S NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

INSURED'S SS#: \_\_\_\_\_ INSURED'S DOB: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY/ST/ZIP CODE: \_\_\_\_\_

HOME PH: \_\_\_\_\_ DAYTIME #: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ EMPLOYMENT STATUS: \_\_\_\_\_

**Secondary Insurance Information:**

INSURED'S NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

INSURED'S SS#: \_\_\_\_\_ INSURED'S DOB: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY/STATE/ZIP CODE: \_\_\_\_\_

HOME PH: \_\_\_\_\_ DAYTIME #: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ EMPLOYMENT STATUS: \_\_\_\_\_

**Emergency Contact Information:**

EMERGENCY CONTACT NAME: \_\_\_\_\_

EMERGENCY CONTACT PHONE: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

Medical Record Number \_\_\_\_\_ Account Number \_\_\_\_\_



RC23500

REV - 02/25/08 Form # RC23517

**BAPTIST HOSPITAL  
Outpatient and Sports  
Rehabilitation  
Demographic Sheet**

Permanent Chart Document

PATIENT LABEL

To better facilitate your care and insure that your medical record is complete, please take a few minutes to answer the questions below. Please be as specific as possible. Thank you.

1. What medications are you currently taking? Please be as specific as you can.

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2. Do you have any allergies?  No  Yes: If yes explain:

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3. If the patient is under the age of 18, are immunizations up to date?  Yes  No

4. What are your goals for therapy? What do you hope to achieve by coming to therapy?

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5. How do you feel you learn best?

Written instructions

Pictures

Verbal instructions

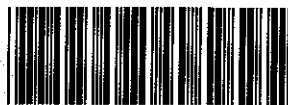
Demonstration

Combination of all

Signature of person completing form: \_\_\_\_\_

Relationship to the patient: \_\_\_\_\_

Date: \_\_\_\_\_



RC23500

REV - 05/02/05 Form # RC23523

**BAPTIST HOSPITAL**  
**Outpatient and Sports**  
**Rehabilitation**  
**Medication/Allergy**  
Permanent Chart Document

PATIENT LABEL