Rehab in Motion...
REBOUND
PHYSICAL, OCCUPATIONAL & HAND THERAPIES

Patient Intake Form

www.reboundot.com Bellingham ▪ Lynden

Patient Information

First Name_____ MI_____ Last Name_____
DOB_____ / _____ / _____ Age:_____ Social Security # _____ - _____ - _____ Gender:_____
Address_____
Street City State Zip
Email Address_____
Home Phone (_____)_____ - _____ Work Phone (_____)_____ - _____ Cell Phone (_____)_____ - _____

Responsible Party (if other than patient)
Name_____ Home phone (_____)_____ - _____ Work phone (_____)_____ - _____
Address_____
Street City State Zip

Emergency Contact

Name_____ Relationship_____ Phone (_____)_____ - _____

Employer

Employer Name_____ Phone (_____)_____ - _____
Address_____
Street City State Zip

Injury Information

Referring Physician_____ Primary Care Physician_____
Date of Injury_____ Injury/Body Part_____ Date of Surgery_____
Employment Related? ◯ Yes ◯ No Auto Accident? ◯ Yes ◯ No Available PIP? ◯ Yes ◯ No
Responsible Party_____ Phone (_____)_____ - _____
Adjuster / Claim Manager Name_____ Phone (_____)_____ - _____
Have you had previous PT or OT this year? ◯ Yes ◯ No Are you receiving any in-home therapy? ◯ Yes ◯ No

Insurance Information

Primary Insurance_____ Subscriber's Name_____
DOB_____ /_____ /_____ ID Number_____ Group Number_____

Secondary Insurance_____ Subscriber's Name_____
DOB_____ /_____ /_____ ID Number_____ Group Number_____

I hereby authorize my insurance benefits to be paid directly to the provider of these services. I am financially responsible for any balance due, including services that are not covered by my insurance plan. I hereby authorize release of all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature_____ Date_____
(Parent or Guardian if patient is a minor)