Last Name: _____ **First Name:** _____ Sex: Male Female

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: (____) _____ Work Phone: (____) _____ Home Phone: (____) _____

Date of Birth: Month _____ Day _____ Year _____ Age: _____ Marital Status: Single Married Divorced Widowed

Social Security #: _____-_____-_____ # of Children: _____ Ages of children:_____

Email address_____

What is the best way to contact you regarding your treatment schedule?

Please circle all that apply: Text Message Email Phone call

Emergency contact information: Name: _____

Phone #: _____ Relationship: _____

Please circle one of the following: Employed Unemployed Student Homemaker

Employed by: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

If unemployed, is it due to the accident? If yes, why? _____

Attorney's Name: _____

Address: _____ Phone #: _____

How were you referred to our office? Online Family/Friend (please list name): _____

Insurance of person at fault: _____

Address: _____ Adjuster: _____

Claim #: _____ Phone #: _____

Insured's Name: _____Policy #: _____

Your Auto Insurance Co. (or insurance of the vehicle you were a passenger in): _____

Address: _____Adjuster: _____

Claim #: _____ Phone #: _____

Policy #: _____Auto Med-pay coverage: Yes or No

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that Medical Rehab Accident Injury Center/Metairie will prepare any necessary reports and forms to assist me in making collection from the insurance company and any amount authorized to be paid directly to this office will be credited to my account upon receipt. I understand and agree all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand if I suspend or terminate my care and treatment prior to release, any fees for professional services are my responsibility. Appointment reminders will be sent to a mobile device as per your preference above. Medical Rehab assumes no liability for fees that result from that contact. I give Medical Rehab permission to contact me to remind me of my treatment schedule.

Signature: _____ Date: _____

PAST MEDICAL HISTORY:

Surgeries: _____

_____

Fractures: _____

_____

Serious Illness: _____

_____

Car Accident/ Worker's Comp/ Slip & Fall: _____

_____

Were you a patient in our office before? Yes or No

If so, when? _____

Any prior history or treatment of current complaints? _____

_____

Current Weight: _____ Height: _____ Please circle: Right-handed Left-handed

Please check:	None	Light	Moderate	Heavy
Exercise				
Smoke				
Drink Alcohol				
Experience Stress				

Medications (include over the counter) - Name and how often taken:

_____

_____

List any known/suspected allergies: _____

FAMILY HISTORY:	List family member relation:	List family member relation:	List family member relation:
Cancer			
Diabetes			
Stroke			
Heart condition			
High Blood Pressure			
Other			

PREGNANCY RECORD: (for females only) **Are you pregnant: Yes No Unsure**