ST ELIZABETH SERIES DEPARTMENT **INTAKE SHEET**

Date of Call ____________ **Date & Time of Appt** ________________ **Date Faxed to Ins.** ______________________

Department/Patient Type

CAR ☐	DMG ☐	HND ☐	WND/HB ☐	PTS/GR ☐	PTS/S ☐	PTS/TM ☐	CSD ☐	RJM
SPA ☐	DMG/OB ☐	HEM ☐	WND ☐	PTS/N ☐	PTS/HEB ☐	PTS/UN ☐		NJM
Nutri ☐			SMC E	SMC F	SMC S	☐		RFH

PATIENT INFORMATION

Last Name: First: I: Date of Birth:

Address: City: State: Zip Code: Cty:

Home Phone: SSN: Sex: Race: Marital Status:

Employer: Occupation: Emp Status: Student:

Employer Address: Emp Phone:

Patient's Primary Languauge: Communication Needs:

NEXT OF KIN/INSURANCE CARRIER INFORMATION

Last Name: First: I: Date of Birth:

Address: City: State: Zip Code: Cty:

Home Phone: SSN: Sex: Race: Marital Status:

Employer: Occupation: Emp Status: Student:

Employer Address: Emp Phone:

Relationship to Patient:

MEDICAL/ACCIDENT INFORMATION

Ordering Physician: Referring/Family Physician:
(please include first and last name)

Diagnosis: Type of Accident: Date of Acc:

Time of Accident: Place of Accident: Nature of Accident:

Insurance #1 (Please fax copy of card (front and back) to Registration

Insurance Co Name: Subscriber Name:

Mail to Address: Phone #:

Policy/ID#: Group#:

If Workers Comp (KY or OH): Claim#:

Benefit Information:

Eff Date: Co-Pay: Co-Insurance:

Deductible: Out of Pocket:

Spoke With: # of Visits Allowed: Precert Required: Auth#:

Insurance #2 (Please fax copy of card (front and back) to Registration

Insurance Co Name: Subscriber Name:

Mail to Address: Phone#:

Policy/ID#: Group#:

If Workers Comp (KY or OH): Claim#:

Benefit Information:

Eff Date: Co-Pay: Co-Insurance:

Deductible: Out of Pocket:

Spoke With: # of Visits Allowed: Precert Required: Auth#:

Comments: