Oswego Hospital

Rehabilitation Services Registration Information

Name:______________________________________ DOB:______________ SS #:_____-_____-_____

Address:____(315)_____________

Street/PO Box City State Zip Phone #

Place of Employment:____ Phone #: (315)______________

Insurance:_______________________________ Co-Pay $__________ ID/Claim #:_________________

_________________Worker's Comp _________________No Fault

Spouse or Nearest Relative:__________________________________ Indicate Relation:______________

Referring Physician: ____

Next follow-up appointment with Referring Physician:___________________

Month / Day/ Year

Briefly explain what the "problem" is that you are seeking treatment for:___________________________

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How did it happen?____ When did it start? ____________

Have you had?

____ Surgeries: ____

____ Broken Bones: ____

____ Home Care Services in the last month, If so which agency: _______________

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___High Blood Pressure ___Cancer ___Diabetes ___Heart Problems ___Pacemaker

___Breathing Problems ___Circulation/Bleeding Problems ___Is there a chance you may be pregnant?

Authorization for Release of Information: *I have received the information regarding HIPPA and the Health Care Proxy. I, the undersigned do hereby authorize Oswego Hospital Rehabilitation Services to release any information to my Insurance Company and/or Physician relating to my Physical, Occupational, and/or Speech Therapy. The above information is correct to the best of my ability/knowledge.*

____ ______________________

Signature Date

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Office Use Only

Data:________ Assessment sent MD________ Insurance Contacted________ ICD 9#:________

Comments: ____

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