COASTAL REHAB
PHYSICAL THERAPY + SPORTS + SPINE

Patient Data

Today's Date:	**Date of Birth:**	**Age:**	**SSN:**
Last Name:	**First Name:**		**Middle Initial:**
Street Address:	**City:**	**State:**	**Zip Code:**
Mailing Address:	**City:**	**State:**	**Zip Code:**
Home Phone:	**Mobile Phone:**	**Sex:** ☐ Male ☐ Female	**Status:** ☐ Married ☐ Widowed ☐ Single ☐ Other
Email Address:			
Emergency Contact:	**Relation:**	**Phone:**	
Are you Employed? ☐ Yes ☐ No ☐ Retired	**Employer:**	**Occupation:**	
Referring Doctor & Phone Number:	**Primary Care Physician & Phone Number:**		

Current Episode of Care (Required)

Date of Injury/Pain Onset:	**Auto Related?** ☐ Yes ☐ No	**Work Related?** ☐ Yes ☐ No	**Other Accident Related (Explain):**
Surgery Related? ☐ Yes ☐ No	**If Yes, Date of Surgery:**	**Area of Injury/Pain:**	
Are you currently receiving any Home Health Services? ☐ Yes ☐ No		**If Yes, Indicate Agency:**	
Are you currently a resident of a skilled Nursing Facility? ☐ Yes ☐ No		**If Yes, Indicate Facility & Discharge Date:**	
Have you received Physical, Occupational, Speech Therapy, and/or Chiropractic Care within the last 12 months? ☐ Yes ☐ No		**If Yes, Indicate Facility:**	
Auto Accident? ☐ Yes ☐ No	**If yes, what state?**	**Other Accident in which someone else is at fault?** ☐ Yes ☐ No	
Will you be seeking reimbursement for your out of pocket expenses from a third party? ☐ Yes ☐ No			

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Insurance (Please present cards, list coverage in the order it is to be filed)

Primary Insurance:	**ID Number:**	**Subscriber:**	**Subscriber SSN:**	**Relation to Patient:**
Secondary Insurance:	**ID Number:**	**Subscriber:**	**Subscriber SSN:**	**Relation to Patient:**
Tertiary Insurance:	**ID Number:**	**Subscriber:**	**Subscriber SSN:**	**Relation to Patient:**

If patient is a minor, please provide the following responsible party information

Responsible Party Name:	**Date of Birth:**	**Phone Number:**	**SSN:**	
Relationship to Patient:	**Street Address:**	**City:**	**State:**	**Zip Code:**
If Medicaid, please provide school name:				

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