

**Orthopedic Rehabilitation Specialists
Patient Intake Form**

Name_____

Address_____City/State/Zip_____

Phone#_____ Cell #_____ Work #_____

Date of birth_____ Gender_____ SSN_____

Emergency contact

Name/number_____

Employer name/address_____

Employer phone#_____ Occupation_____

Referring Physician_____ Date of next appt_____

Primary Care Physician_____

X-rays: Y / N MRI: Y / N Where were they done_____

I authorize release of medical information to/from ORS- Re:_____

Signature_____ **Date**_____

Problem description_____

Date of onset/injury_____

Primary Insurance

Insurance_____ Subscriber_____

Secondary Insurance

Insurance_____ Subscriber_____

I have been offered a copy of ORS Notice of Privacy Practices.

I authorize payment of medical benefits directly to ORS. I authorize ORS to release any information necessary to process this claim. I understand that I am responsible for any charges not reimbursed by my insurance carrier.

Signature_____ **Date**_____