County General Hospital

INFO TAKEN BY: _____

Date Of Call	Patient Account # 999999		Last Visit	Physical Therapist
Patient Name: Smith, Susan		Middle Initial: G		
Contact: (H) (W) (C) Email :				
Emergency Contact: Ph #s: DOB: 01/01/1960 Sex: F Marital Status: Divorced Op Report:			Job Desc:	
SSN: 111-22-3333		Employer:		
Current Rx Signed on:		Receiving Skilled Nursing?		Previous Physical Therapy:
Mailing Address:				
Treatment Address:				
Facility: Country General		Additional Info:		
Referring MD:		MD to receive notes?	PCP MD:	MD to receive notes?
Frequency:				
RX: **ICD - 9 Diagnosis:** DOI: DOS:				
Primary Insurance: Medicare A		Subscriber #: 1110001		
Adjuster:		Address:	Phone #s:	
Injured Person:		DOB:	Relation:	
Date:	S/W:	Coverage:	Deductible:	Start / End Date: # of Visits:
Secondary Insurance:		Subscriber #:		
Adjuster:		Address:	Phone #s:	
Injured Person:		DOB:	Relation:	
Date:	S/W:	Coverage:	Deductible:	Start / End Date: # of Visits:

I _____ have reviewed and attest to the accuracy of the information.

SIGNATURE: _____ DATE: _____

County General Hospital

INFO TAKEN BY: _____

Date Of Call	Patient Account # 999998		Last Visit	Physical Therapist
Patient Name: Johnson, Bubba		Middle Initial: A		
Contact: (H) (W) (C) Email :				
Emergency Contact: Ph #s: DOB: 12/01/1966 Sex: M Marital Status: Single				Job Desc: Op Report:
SSN: 111-22-4444		Employer:		
Current Rx Signed on:		Receiving Skilled Nursing?		Previous Physical Therapy:
Mailing Address:				
Treatment Address:				
Facility: Country General		Additional Info:		
Referring MD:		MD to receive notes?	PCP MD:	MD to receive notes?
Frequency:				
RX: **ICD - 9 Diagnosis:** DOI: DOS:				
Primary Insurance: BCBS		Subscriber #: 1110002		
Adjuster:		Address:	Phone #s:	
Injured Person:		DOB:	Relation:	
Date:	S/W:	Coverage:	Deductible:	Start / End Date: # of Visits:
Secondary Insurance:		Subscriber #:		
Adjuster:		Address:	Phone #s:	
Injured Person:		DOB:	Relation:	
Date:	S/W:	Coverage:	Deductible:	Start / End Date: # of Visits:

I _____ have reviewed and attest to the accuracy of the information.

SIGNATURE: _____ DATE: _____