THE SHOOK
REHABILITATION &
WELLNESS CENTER

Phone: 717-264-6815 Fax: 717-264-0104
55 South Second Street, Chambersburg, PA 17201
www.shookhome.org

Continuing Care Retirement Community

New Patient Information

Name:_____ **M F** SS#: _____-____-_____ DOB ____/____/_____
First Last Gender

Mailing Address: _____ Zip: _____

Home #: _____ Cell/Work #: _____ Email Address: _____

Referring Physician: _____Patient's Problem: _____

Primary Care Physician: _____ Service Required: PT OT ST

Have you received PT, OT, SP since January 1st of this year? Yes / No If yes, then where? _____
Have you received past or current Chiropractic care? Yes/No

Injury Date: ____/____/_____ Surgery Date: ____/____/_____ WC Auto Other State: _____

( ) Patient has Rx ( ) MD to fax Rx Script Exp.: _____

Primary Insurance: _____**Phone #**:_____

Address: _____

Insured Name: _____Relation: _____ SS#: _____-____-_____ DOB: ____/____/_____

ID# _____ GRP #: _____

Employer: _____ Employer Address: _____

WC or AUTO Claim #: _____ Adjuster: _____

Secondary Insurance: _____ **Phone #**: _____

Address: _____

Insured Name: _____Relation: _____ SS#: _____-____-_____ DOB: ____/____/_____

ID# _____ GRP #: _____

Emergency Contacts (1):

Name:_____ Relationship: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Emergency Contacts (2):

Name:_____ Relationship: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

How did you learn about Shook Home Rehab and Wellness Center: _____

_____

Stop here and return to receptionist

Facility Use Only

Medicare Part B Primary / Secondary Effective Date: _____

Ins pays: _____ Co-Ins: _____

Deductible: _____Met: YES / NO Amt. Applied: _____

Therapy Cap: PT/SP _$2010__ OT_$2010__ Per: **cal year / bene period**

$ Therapy Cap used: PT/OT _____ SP_____

PRIMARY INSURANCE

Spoke With: _____ Date: _____ Initials: _____ In / Out of network Effective Date: _____

Ins pays: _____ Co-Ins: _____ Out of pocket Max: _____ Amt. Applied: _____

Co-Pay: _____ per visit/day Deductible: _____ Met: YES / NO Amt. Applied: _____

# of visits: PT _____ OT _____ SP_____ Per: **cal year / bene period** What is the patient's calendar year? _____

# of visits used: _____ # of visits remaining: _____

Insurance Referral: YES / NO Auth Process required: YES / NO (explain below) Pre-auth required: YES / NO (explain below)

SECONDARY INSURANCE

Spoke With: _____ Date: _____ Initials: _____ In / Out of network Effective Date: _____

Ins pays: _____ Co-Ins: _____ Out of pocket Max: _____ Amt. Applied: _____

Co-Pay: _____ per visit/day Deductible: _____ Met: YES / NO Amt. Applied: _____

# of visits: PT _____ OT _____ SP_____ Per: **cal year / bene period** What is the patient's calendar year? _____

# of visits used: _____ # of visits remaining: _____

Insurance Referral: YES / NO Auth Process required: YES / NO (explain below) Pre-auth required: YES / NO (explain below)

AU/**WC** claims: Spoke with: _____ Date: _____ Diagnosis Verified: _____Date of claim: _____

State: _____ If not PA, Auth Needed? YES / NO (Explain below) Nurse Case Manager (WC)_____