Outpatient Rehabilitation and Sports Medicine
Patient Information Form

Place Patient Label Here

Name: ______________________________________

Date of Birth: _________ SSN__________________

❑ Single ❑ Married ❑ Widowed ❑ Divorced

Mailing Address:
Street ______________________________
City: _______________Zip: ________-____

Cell Phone: __________________

Home Phone: _________________

Emergency Contact Information:
Name: __________________________________

Relationship: _____________________________

Address: _________________________________

Cell: _____________ Home: _____________

Insured Information:

❑ Self ❑ Spouse: Employer Name____________
❑ Parent/Guardian

Name ________________________________

Date of Birth ___________ SSN ________________

Mailing Address:
Street ______________________________
City: _______________Zip: _______-____

Cell: _______________Home: __________________

❑ Workers Compensation
Adjuster or Nurse Case Manager Name / Phone #:

____

(Please provide the front desk with any paperwork you may have with you today)

Employment Status:

- ☐ Employed / Employer: _______________
- ☐ Disabled
- ☐ Retired / Date of Retirement: ___________
- ☐ Not Employed

Reason for therapy today? ______________________

Past Medical History: ___________________________

Surgeries: ___________________________________

Family Physician: ______________________________

Outpatient Rehabilitation and Sports Medicine
Therapy Policies

Thank you for selecting McLeod Rehab and Sports Medicine Services for your therapy. We are excited to be part of your care. We ask you to follow these policies to assure you receive the best experience, and maximum benefit from your therapy.

1. Please communicate your scheduling needs with your therapists. Please be sure we have a working phone number on file for you.

   If you will be late, please give us a call at 843-777-2196, option 2. We will notify your therapist and we will do our best to reschedule your appointment.

   If you need to cancel, please call the clinic 24 hours prior to your appointment time. Missing 3 or more visits may result in a discharge from therapy services. Your therapy may be less effective if your attendance is not regular.

2. Due to safety, privacy, and space restrictions, we request that your friends and family members wait for you in the lobby, unless requested by your therapist.

3. For their safety, children under age 16 may not be left unattended at any time.

________________________________ ______________ ________
Patient name (print) Date of Birth Date

____
Patient Signature

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McLeod Health
The Choice for Medical Excellence

Place Patient Label Here

MCLEOD OUTPATIENT REHAB AND SPORTS MEDICINE MEDICATION FORM

Patient Name: ________________________ Patient Birth Date:________________________

LIST ALL CURRENT ALLERGIES BELOW:

Allergic To:	Reaction

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: prescription and over-the-counter medications. Include medications taken as needed.

DATE	NAME OF MEDICATION / DOSE	DIRECTIONS (patient friendly)	Notes: Reason for taking/ Doctor Name

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