

MEDISYS

REHABILITATION, INC.

PATIENT INFORMATION FORM

Services Requested (Please check each service needed)

Life Care Plan Neuropsychological (NPE) Psychological Date Report Needed By: ____ / ____ / ____
 Cost Analysis File Review Only Other

Patient Information

Patient Name: _____ Date of Birth: ____ / ____ / ____
Address: _____ Patient SS#: ____ / ____ / ____
City/State/Zip: _____ Primary Language: _____
Home Phone: (____) _____ Secondary Language: _____
Work Phone: (____) _____ Race: _____
Cell Phone: (____) _____ Sex: _____
Email Address: _____ Check here if patient should not be contacted personally

Primary Contact Person (person we should contact if patient is a child or cannot provide information about their injury/care)

1st Contact Person: _____ Home Phone: _____
Relationship to Patient: _____ Cell Phone: _____
Address: _____ Other Phone: _____
City/State/Zip: _____ Email address: _____

2nd Contact Person: _____ 2nd Contact Phone: _____
Relationship to Patient: _____ Home Phone: _____
Address: _____ Other Phone: _____
City/State/Zip: _____ Email address: _____

Injury Information and Medical Records

Check all injuries that apply Brain Injury Paraplegia Quadriplegia Amputee Cerebral Palsy Brachial Plexis Other

Please provide a brief description of injury:

Date of Injury:

Referral Source or Attorney Information

Attorney Name: _____ Office Location: _____
Attorney Firm Name: _____ Paralegal Name: _____
Direct or Mobile phone: _____ Paralegal Email: _____
Attorney email address: _____ Paralegal Phone: _____

Style of the case: _____ Please check one: Plaintiff Defense

Please send the completed form to our office along with the fee schedule contract, retainer, medical records and questionnaires (if LCP or NPE).
Please feel free to contact us by phone or email at any time.