United Therapeutics Corp.
Institute for Physical Rehabilitation

Patient Name: _____
Date: _____

GENERAL INFORMATION

Please complete all of the following information. Please ***print*** clearly.

Patient Name:_____ _____ _____
(Last) (First) (MI)

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: (home) _____ (work) _____ Cellular Phone: _____

Date of Birth: _____/_____ /_____ Sex: ☐ Male ☐ Female Social Security #: __ __ __ / __ __ / __ __ __ __

E-mail: _____

Primary Care Physician: _____ Phone: _____

Refering Physician: _____ Specialty: _____ Phone: _____

Date of Last Visit with Referring Physician: _____

Date of Next Return Visit with Referring Physician: _____

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Occupation: _____

Is current injury WORK RELATED?: ☐ No ☐ Yes If yes, claim number: _____

Case Manager's Name: _____ Phone: _____

Is current injury related to an AUTO ACCIDENT?: ☐ No ☐ Yes If yes, claim number: _____

Adjuster's Name: _____ Phone: _____

Primary Insurance Carrier: _____

Group #: _____ ID#: _____

Secondary Insurance Carrier: (if applicable) _____

(If different from above) Group #: _____ ID#: _____

Name of Insured, if different from patient: (person who holds the policy): _____

Date of Birth: _____ / _____ / _____ Sex: ☐ Male ☐ Female

Relationship to Patient being seen today: : ☐ Parent ☐ Spouse ☐ Other _____

Patient Signature: