McLaren
GREATER LANSING

**Name:** _____
**Preferred Name**: _____**email:**_____

**Date of Birth:** _____
**Social Security**: _____

**Address: Street:** _____
**City:** _____, ZIP: _____
**County:** _____
**Phone: Primary: Cell/Home/Work:** _____
**Secondary: Cell/Home/Work**: _____

**Marital Status:** Married/Single/Divorced/Widowed
**Primary Language Spoken:** English…Other _____
**Race:** White/African American/Asian/Hispanic/Other
**Ethnicity:** Hispanic/Latino or Non Hispanic/Latino
**Religious Preference**: _____

**Employer:** _____
**Address: Street:** _____ **City:** _____, ZIP:_____
**Employment Status:** Full time/Part time/Not Employed/Retired/Self Employed
**Retirement Date**: _____

**Primary Insurance**: _____
Contract Number: _____, Group Number:_____
Policy Holder: _____, DOB: _____, SSN _____
Policy Holder Employer: _____
Policy Holder Employer Address: _____, City _____,ZIP _____
**Secondary Insurance**: _____
Contract Number: _____, Group Number: _____
Policy Holder: _____, DOB: _____, SSN _____
Policy Holder Employer: _____
Policy Holder Employer Address: _____, City _____, ZIP _____
**Emergency Contact:** _____, DOB:_____
**Relationship:** _____ **Phone**: Cell/Home/Work:
_____**Address:** _____,
City: _____, ZIP _____
**Family Doctor**: _____
**Referring Doctor:** _____
Date of injury:_____ Surgery? Y/N Date:_____

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OFFICE USE ONLY
Diagnosis: _____ Script: PT/OT Signed by: MD/DO/PA/NP/MA
Date on Script: _____ New Script Needed: Called _____ Received _____ Date: _____
Paperwork: Mailed/Emailed/Picked up/Faxed Date Scheduled: M/T/W/Th/F: _____
Therapist: HF/SK/TRC/DM/JP/AS/LW/GC/PC

If you are a Medicare recipient, please answer the following questions required by Medicare:

1. Are you eligible for Medicare based upon (circle one or more)
    a. Age
    b. Disability
    c. End-Stage Renal Disease
2. Are you receiving Black Lung Benefits?
    a. Y/N Date benefits began ____/____/_____
3. Have you participated in a government medical research program, in which services at this facility are being paid for?
    a. Y/N
4. If you are a Veteran, has Veteran Affairs authorized/agreed to pay for care at this facility?
    a. Y/N
5. (If applicable) Does your group insurance employer employ more than 20 employees?
    a. Y/N
    b. More than 100 employees? Y/N
6. Have you ever worked outside the home?
    a. Y/N
7. Has your spouse ever worked outside the home?
    a. Y/N
8. Is your spouse retired?
    a. Y/N
    b. Date retired? ____/____/_____