VIBRANTcare REHABILITATION

TODAY'S DATE _____

PATIENT INFO.

Name: _____

DOB: _____

Address: _____

City: _____ **State:** ____ **Zip:** _____

Phone: ( ) _____

Guarantor: _____

REFERRING PHYSICIAN INFO

Name: _____

MD Signature:_____

Address:_____

City: _____ **State:** _____ **Zip:** _____

Phone: ( ) _____

Fax: ( ) _____

Main Contact Person:_____

INSURANCE

Insurance Company: _____

Policy Number: _____

Phone: ( ) _____

Authorization Number: _____

PRIMARY CARE PHYSICIAN (If different from above)

Name: _____

Address: _____

City: _____ **Zip:** _____

Phone: ( ) _____

VIBRANTCARE CLINIC LOCATION: Sugar Land

☐ **EVAL & TREAT**_____ ☐ **FREQ & DUR.**_____**/PER WK X** _____**/WKS**

- ☐ Orthopedic – Adult
- ☐ Orthopedic – Pediatrics
- ☐ Sports Physical Therapy
- ☐ Musculoskeletal Injuries
- ☐ Dry Needling
- ☐ Cupping
- ☐ Vestibular
- ☐ Fall Risk
- ☐ Workers' Comp
- ☐ Work Conditioning
- ☐ Pelvic Floor Therapy

☐ Other: _____

Diagnosis / ICD-10 / Special Instructions: