University of Evansville

Ace PT · ACErcise · AceBuddies

AceCARE
COMMUNITY ACTION THROUGH REHABILITATION AND EDUCATION

Patient Information

First name: _____ MI: _____ Last name: _____

Address 1: _____

City: _____ State: _____ Zip Code: _____

Home phone: _____ Cell phone: _____ Date of birth: _____

Please circle first contact preference

Social Security Number: _____ Email Address: _____

Employer and employer phone number: _____

Employer address: _____

General physician: _____

Second contact person name: _____

Second contact person address: _____

Phone number: _____ Relation: _____

Work related? Yes No If yes, date of injury: _____

Related to a motor vehicle accident? Yes No If yes, state and date of accident: _____

How did you hear about us? ☐ Physician Referral ☐ Family or Friend ☐ Industry

☐ Other (please list): _____

I authorize the staff of this rehabilitation facility to provide treatment to me as directed by my referring physician. I authorize the release of any medical information necessary and as stated in the previous privacy policies. I authorize the release of clinical information to my referring physician.

Signature: _____ **Date:** _____

Parent/legal guardian signature: _____ Date: _____

Relationship to the patient: _____

_____ I have been given the Notice of Privacy Practice, AND have been made aware, and copies available to me, of the Rights. If I have any questions, I can contact the Compliance Officer at 812-488-2579.

Patient Initials