



## Rejuv Medical

901 3rd St. N.  
 Waite Park, MN 56387  
**Scheduling:** 320-217-8480  
**Fax:** 320-217-8490

<b>PATIENT INFORMATION</b>									
Patient Name		Primary Phone		Secondary Phone					
Patient DOB		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Patient will call to schedule		<input type="checkbox"/> Call patient to schedule			
<b>INSURANCE INFORMATION</b>									
<input type="checkbox"/> Commercial/Private				<input type="checkbox"/> Auto <input type="checkbox"/> Workers' Comp		Date of Injury			
Insurance Carrier				Insurance Carrier		Claim #			
Member #				Group #		Adjuster		Phone #	
				Attorney		Phone #			
<b>REFERRING PROVIDER INFORMATION</b>									
Clinic Name					Phone			Fax	
Clinic Address					City		State		Zip
Provider Name (Print)									
*Provider Signature (Required) - *fully typed name constitutes my legal signature									
<b>Evaluate &amp; Treat:</b>									
<input type="checkbox"/> Headaches		<input type="checkbox"/> Lumbar/SI		<input type="checkbox"/> Knee		<input type="checkbox"/> Foot		<input type="checkbox"/> Cervical	
<input type="checkbox"/> Pelvis/Hip		<input type="checkbox"/> Ankle		<input type="checkbox"/> Shoulder		<input type="checkbox"/> Elbow		<input type="checkbox"/> Wrist	
<input type="checkbox"/> Fingers		<input type="checkbox"/> Other:							
<b>Insurance Covered Options:</b>									
<input type="checkbox"/> Functional Medicine			<input type="checkbox"/> Primary Care			<input type="checkbox"/> Physical Therapy			<input type="checkbox"/> Brace Fitting
<input type="checkbox"/> Trigger Points			<input type="checkbox"/> Tenotomy			<input type="checkbox"/> Joint Injections			<input type="checkbox"/> Carpal Tunnel Injections
<input type="checkbox"/> Tendon Injections			<input type="checkbox"/> Bursal Injections			<input type="checkbox"/> Nerve Blocks			<input type="checkbox"/> Lumbar Epidural
<b>Non-Insurance Covered Options:</b>									
<input type="checkbox"/> Stem Cell			<input type="checkbox"/> PRP			<input type="checkbox"/> Prolotherapy			<input type="checkbox"/> Platelet Lysate
<b>Fitness Options:</b>									
<input type="checkbox"/> Gym Membership			<input type="checkbox"/> Personal Training				<input type="checkbox"/> Group Fitness		
<input type="checkbox"/> BioSCORE Test			<input type="checkbox"/> Metabolic Test			<input type="checkbox"/> Health Coaching			

Please release related records or imaging from the last 6 months to Rejuv Medical.

\*Patient Signature (Required) \_\_\_\_\_  
 \*fully typed name constitutes my legal signature