

# REFERRAL SOURCE INFORMATION

## AFFILIATED HEALTH OF WISCONSIN PAIN REHABILITATION ASSOCIATES – PHYSICAL THERAPY

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Account Number: \_\_\_\_\_

Please inform us with the following information regarding other health care providers that are also treating you for your health care needs so we may inform them regarding your progress if necessary.

1. Who is your referring doctor, therapist or other health care provider:

Name: \_\_\_\_\_

Phone No: \_\_\_\_\_

I was not referred here by a doctor.

2. Did any other health care provider recommend our services?:  Yes,  No

If Yes: Name: \_\_\_\_\_

Phone No: \_\_\_\_\_

3. Do you see any other health care providers for the same problem?:  Yes,  No

If Yes: Name: \_\_\_\_\_

Phone No: \_\_\_\_\_

4. Who is your primary care physician?

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

I don't have a primary care physician

5. Who is your current dentist?

Name: \_\_\_\_\_

Phone No: \_\_\_\_\_

6. For our marketing department please inform us with the following:

How did you hear about us?

|                          |   |                          |                    |
|--------------------------|---|--------------------------|--------------------|
| <input type="checkbox"/> | Doctor listed in question 1             | <input type="checkbox"/> | Other:             |
| <input type="checkbox"/> | Health Insurance Book                   | <input type="checkbox"/> | Wisconsin Woman    |
| <input type="checkbox"/> | Internet / website                      | <input type="checkbox"/> | Exchange / Outpost |
| <input type="checkbox"/> | Television                              | <input type="checkbox"/> | Seminar            |
| <input type="checkbox"/> | Friend/Family/Employee*                 | <input type="checkbox"/> | Sign               |
| <input type="checkbox"/> | Yellow Pages                            | <input type="checkbox"/> | Radio              |
| <input type="checkbox"/> | Arthritis Foundation / Magazine / Flyer | <input type="checkbox"/> | Coupon             |

\*For Friend/Family/Employee, who may we thank:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_