Marianjoy
Rehabilitation Hospital

Now part of
Northwestern Medicine

Outpatient Therapy Registration

Patient Last Name: ______________________ **First Name:** ______________________ **M.I:** ____

Date of Birth (MM/DD/YY): ______________________ **Sex: M F** ______

Street Address: ____

City: ______________________ **State:** ____________ **Zip:** ____________

Home Ph#: ______________________ **Other Ph#:** ______________________ **(/Wk/Cell/Oth)**

Marital Status: ____________ **Race:** ____________ **Ethnicity:** ____________

Preferred Spoken language for Healthcare: ______________________ **Interpreter Required: Y / N**

Social Security#: ______________________ **Religion Preference :** ____________

Email Address: ____

Employer Name: ____

Employer Street Address: ____

Employer City: ______________________ **State:** ________ **Zip:** ____________

Employer ph#: ______________________ **Employment Status: (FT/PT/UE/Minor/DIS/SE)**

Next Of Kin Name: ____ **(Must be a relative)**

Street Address: ____

City: ______________________ **State:** ____________ **Zip:** ____________

Home Ph#: ______________________ **Other Ph#:** ______________________ **(/Wk/Cell/Oth)**

Relationship to Patient: ____

Emergency Contact Name: ____

Street Address: ____

City: ______________ **State:** ______________ **Zip:** ______________

Home Ph#: ______________ **Other Ph#:** ______________ **(/Wk/Cell/Oth)**

Relationship to Patient: ______________

Insurance Carrier Name: ______________

Claim Mailing Address: ______________

____

City: ______________ **State:** ______________ **Zip:** ______________

Claim ph#: ______________

Patient Identification #: ______________ **(Not always same as SS#)**

Name of Insured/Policy holder: ______________

Insured/Policy holder street address: ______________

City: ______________ **State:** ______________ **Zip:** ______________

Insured Relationship to Patient: ______________ **Sex: MF** ______

Insured Social Security#: ______________ **Marital Status:** ______________

Group Name: ______________ **Group #:** ______________

Insured/Policy holder Employment Status: ______________ **(FT/PT/DIS/SE/UE)**

Insured/Policy holder Employer Name: ______________

Street Address: ______________

City: ______________ **State:** ______________ **Zip:** ______________

Date of Injury/accident and/or Date symptoms first began: ______________

Referred to Marianjoy by: ______________

Name of Ordering Physician: ______________

Street Address: ______________

City: ______________________________ State: ______________ Zip: ______________

Name of Family/Other Physician involved with care: ______________________________

Street Address: ______________________________

City: ______________________________ State: ______________ Zip: ______________

Preferred Pharmacy: ______________________ Ph#: ______________________

Pharmacy Address: ______________________ City: ______________ Zip: __________

Date physician order written/signed: ______________________

Reason for Visit: (as stated on the physician order) ______________________________

____

Diagnosis: (as stated on the physician order) ______________________________

Description of therapy ordered with Frequency and duration: ______________________

____

____

Has Patient received Home Health services in the past 90 days: Y / N

Name of Home Health Agency: ______________________________

Agency street address: ______________________________

City: ______________________________ State: ______________ Zip: ______________

Agency ph#: ______________________ Dates received: ________ to ______________

Do you have a current 'Do Not Resuscitate' status? Y / N

If 'Yes' patient must provide DNR form at time of admission

How did you hear about Marianjoy: ______________________________

____

Race Ethnicity Information

During the registration/admission process we are required to ask you questions related to your race, ethnicity and preferred language.

In addition to meeting a number of mandated regulatory and accreditation requirements, this information will aid in our ability to provide health care equally to all the patients we serve in line with the Wheaton Franciscan Healthcare System's value of RESPECT for all.

We appreciate your indulgence as we complete this process.

RACE

Mnemonic	Response
AA	African American/Black
AS	Asian
CA	Caucasian / White
D	Declined
NA	Native Amer/Native Alskn
NH	Native Hawaiian/Pacific ISL
OT	Other
un	Unavailable
unk	Unknown

ETHNICITY

Mnemonic	Response
aa	African American/Black
af	African
ar	Arab
as	Asian Indian
bl	Black
ba	Bahamian
bos	Bosnian
br	British / English
bur	Burmese
ca	Central American
cam	Cambodian
cha	Chamorro
chic	Chicano
chin	Chinese
col	Colombian
cro	Croatian
cu	Cuban

Mnemonic	Response
lav	Latvian
leb	Lebanese
lit	Lithuanian
mex	Mexican
mexam	Mexian American
mid	Middle Eastern
moe	More than one ethnicity
nal	Native Alaskan
nam	Native American
nau	Native Australian
nha	Native Hawaiian
ni	Nigerian
no	North African
nor	Norwegian
other	Other (not on the list)
pak	Pakistani
pal	Palestinian

cz	Czech
d	Declined
do	Dominican
eg	Egyptian
ei	East Indian
eth	Ethiopian
fil	Filipino
fr	French
ge	German
gr	Greek
gua	Guamanian / Chamorro
hai	Haitian
his	Hispanic (not specified)
hmo	Hmong
in	Indonesian
ir	Irish
iran	Iranian
iraq	Iraqi
isr	Israeli
it	Italian
jam	Jamaican
jpn	Japanese
jrd	Jordanian
kor	Korean
lao	Laotian
lat	Latino (not specified)
latam	Latin American (not specified)

po	Polish
pol	Polynesian
pr	Puerto Rican
ru	Russian
sam	Samoan
sau	Saudi Arabian
sca	Scandanavian
sco	Scottish
serb	Serbian
slovk	Slovakian
slovn	Slovenian
som	Somalian
souaf	South African
souam	South American
sp	Spanish
sw	Swedish
syr	Syrian
tah	Tahitian
tai	Taiwanese
th	Thai
tib	Tibetan
uk	Ukranian
un	Unavailable
unk	Unknown
viet	Vietnamese
wi	West Indian