Mensana Clinic New Patient Information Form

STEP 1. Please fill out to the best of your ability.

PATIENT INFORMATION:

NAME: ____
PHONE: (H) ____________________(W)____________________
ADDRESS: ____
CITY/STATE/ZIP:______________________________________

INSURANCE INFORMATION:

POLICY HOLDER NAME:_________________________________
POLICY HOLDER SEX: ( ) MALE ( ) FEMALE
POLICY HOLDER BIRTHDATE: ____________________________
POLICY HOLDER EMPLOYER: _____________________________
RELATIONSHIP TO POLICY HOLDER: ( )SELF ( ) SPOUSE ( ) DEPENDENT
INSURANCE COMPANY NAME: ____________________________
PHONE #: ____________________________
POLICY NUMBER: ____________________________________
GROUP NUMBER: ____________________________________

REFERRING PHYSICIAN:

NAME: ____
PHONE: (O)____________________(FAX)__________________
ADDRESS:____
CITY/STATE/ZIP:______________________________________
UPIN#:____

ATTORNEY INFORMATION:

NAME:____-
PHONE:(O)____________________(FAX)__________________
ADDRESS: ____
CITY/STATE/ZIP:______________________________________

TREATING PHYSICIAN(S):

NAME:____-
PHONE:(O)____________________(FAX)__________________
ADDRESS: ____
CITY/STATE/ZIP:______________________________________

NAME:____-
PHONE:(O)_____________________________(FAX)_________________________
ADDRESS: ____
CITY/STATE/ZIP:____

NAME:____-
PHONE:(O)_____________________________(FAX)_________________________
ADDRESS: ____
CITY/STATE/ZIP:____

NAME:____-
PHONE:(O)_____________________________(FAX)_________________________
ADDRESS: ____
CITY/STATE/ZIP:____

NAME:____-
PHONE:(O)_____________________________(FAX)_________________________
ADDRESS: ____
CITY/STATE/ZIP:____

REHAB NURSE(S):

NAME:____-
PHONE:(O)_____________________________(FAX)_________________________
ADDRESS: ____
CITY/STATE/ZIP:____

NAME:____-
PHONE:(O)_____________________________(FAX)_________________________
ADDRESS: ____
CITY/STATE/ZIP:____

NAME:____-
PHONE:(O)_____________________________(FAX)_________________________
ADDRESS: ____
CITY/STATE/ZIP:____

OTHER INFORMATION:

____
____
____
____

STEP 2: This step is only for patients involved in **WORKERS COMPENSATION** cases. If you are not involved with **Workers Compensation,** please skip to STEP 3.

Please complete the following information regarding your Workers Compensation case.

CLAIM NUMBER:____

DATE OF INJURY:____

CLAIMS ADJUSTER:

NAME: ____.

PHONE#:________________________________

INSURANCE COMPANY:

NAME: ___________________________ PHONE #: ______________________.

ADDRESS: ____.

COMPENSABLE INJURIES____

____

____

OTHER INFORMATION:____

____

____

____

STEP 3: This step is only for patients whose medical problems are the result of an **AUTO ACCIDENT.** If you were not involved in an **auto accident**, please skip to STEP 4.

Please provide this information regarding your auto accident.

AUTO CLAIM NUMBER: ____

DATE OF ACCIDENT:____

AUTO INSURANCE COMPANY:

NAME: _________________________ PHONE #: __________________________.

ADDRESS: ____.

CLAIMS ADJUSTER:

NAME: _________________________ PHONE #:___________________________

AVAILABLE PIP:____

OTHER INFORMATION: ____

STEP 4. Send information to Mensana Clinic. Please fax or mail this form to:

Attn: Admissions Coordinator
1718 Greenspring Valley Rd
Stevenson, MD 21153

Fax – (410) 653-3633

How did you hear about us? Please circle all that apply.

Doctor insurance company internet friend article RSD

another patient TV/radio Lightning Strike & Electric Shock conference

attorney other

Thank you for completing and sending your patient information.

Please continue to STEP 5.

STEP 5. Please send a referral from a physician or health care professional involved in your care along with your medical records. This information must be received before we can schedule an evaluation. Please have your physician either fax or mail the following:

1) Medical Referral
2) Medical Records

These should be sent as soon as possible to:

Attn: Admissions Coordinator
1718 Greenspring Valley Rd
Stevenson, MD 21153
Fax – (410) 653-3633
Phone- (866) 653-2403

Once we receive a letter of referral and your medical records from your physician, we will contact you to schedule an initial evaluation with the Clinical Director. If you both agree to ongoing treatment, our staff will assist you in obtaining insurance authorization for your care and scheduling your inpatient or outpatient treatment.

THANK YOU. Please feel free to call with any questions.

Other Options

As a convenience for patients that are unable to travel to Mensana Clinic for an initial evaluation, we offer a medical chart review for the cost of $75. However, we have often found that the information contained in medical charts is not sufficient. Alternately, we offer a self-administered Diagnostic Paradigm which offers the same questions that Dr. Hendler asks during an initial evaluation. Very often this offers more information than can be derived from a medical chart review. The cost of analyzing the Diagnostic Paradigm is $400. The results of both chart reviews and Diagnostic Paradigms will be mailed to you.

If you are interested in either a medical chart review or the Diagnostic Paradigm, please contact our Admissions Coordinator.

Phone (800) 914-5469 ext 69
(410) 337-8508