



Rejuv Medical -Waite Park

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

Rejuv Medical - Savage

14247 O'Connell Court Suite #250
Savage, MN 55378
Scheduling: 952-777-3899
Fax: 952-283-1213

PATIENT INFORMATION			
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
INSURANCE INFORMATION		<input type="checkbox"/> Auto <input type="checkbox"/> Workers' Comp	Date of Injury
<input type="checkbox"/> Commercial/Private		Insurance Carrier	Claim #
Insurance Carrier		Adjuster	Phone #
Member #	Group #	Attorney	Phone #
REFERRING PROVIDER INFORMATION			
Clinic Name		Phone	Fax
Clinic Address		City	State Zip
Provider Name (Print)			
*Provider Signature (Required) - *fully typed name constitutes my legal signature			
Evaluate & Treat:			
<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:		
Insurance Covered Options:			
<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
Non-Insurance Covered Options:			
<input type="checkbox"/> Stem Cell	<input type="checkbox"/> PRP	<input type="checkbox"/> Prolotherapy	<input type="checkbox"/> Platelet Lysate
Fitness Options:			
<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