Patient Registration Information

PERSONAL INFORMATION

Patient Name ______________________________ SS#________________ Date of Birth___/___/___.
First Middle Initial Last MM DD YY

Age ________

Address ______________________________
Street, PO Box Apt. #

____
City State Zip Code

Sex Male Female (Circle One)

Status Single Married Other (Circle One)

Home Phone ( )________________ Cell ____________

Work Phone ( ) ______________________

Email Address ______________________

Parent or Spouse Name ______________________
(Circle One)

Address (if different from above)______________________
Street, PO Box Apt. #

____
City State Zip Code

Patient's Employer ______________________

Address ______________________
Street, PO Box Suite #

____
City State Zip Code

Patient's Occupation ______________________

Emergency Contact______________________

Phone ( )______________________

Insurance Information

Insurance Company Name:______________________________

Secondary Insurance Name:______________________________
(If Applicable)

Consent for Treatment. I hereby give my consent to receive treatment by a rehabilitation provider.
Authorization to Release Payment and Information. I request that payment of authorized insurance benefits be made either to me or on my behalf to Community Rehab, Inc. for any services furnished to me by a rehabilitation provider employed by the same. I authorize any holder of medical information about me to be released to my insurance carrier and its agent for information needed to determine these benefits or the benefits payable for related services.
Our Payment Policy. As a service to you, all insurance will be billed by our office. However, you are responsible to us for payment of your balance. Payments can be made at any time to our office. If you do not have any insurance, payment is expected at the time services are rendered.

Signature ______________________________Date______________________
Note. If you are 18 years of age or younger, a parent or guardian must sign this patient registration form on your behalf

-Office Use Only-

Referring Physician:______________________ Date Last Seen By Physician:________________

Cause of Injury ______________________ Work Related: Yes No Date of Injury ______________

Have you received Home Health Care OR Physical Therapy in the past year? Yes No

If yes, have you been released from care? Yes No Number of visits used for Home Health_____ Number of visits used for PT____

The name of the Home Health Care Company that was used:______________________________

Diagnosis _______ _______ _______ _______ *Area Treated* ________________ *Start Date* ______________

Restart Date ______________