

PATIENT INFORMATION

NAME: _____ DOB: ____/____/____ AGE: _____
Last First MI
ADDRESS: _____
Street/Apt/No P.O. Boxes City State Zip
PHONE: (____) _____ CELL: (____) _____ SOCIAL SECURITY: _____
MARITAL STATUS: S M W D SEX: M F HEIGHT: _____ WEIGHT: _____
(circle one) (circle one)
EMPLOYER: _____ OCCUPATION: _____
ADDRESS: _____ WORK PHONE: (____) _____
NEAREST RELATIVE: _____ PHONE: (____) _____
PRIMARY CARE PHYSICIAN: _____
Name Address Phone
REFERRING PHYSICIAN: _____
Name Address Phone

INJURY RELATED TO: () WORK () SCHOOL () MOTOR VEHICLE () OTHER DATE OF INJURY: ____/____/____

RESPONSIBLE/INSURED POLICYHOLDER INFORMATION

NAME: _____ DOB: ____/____/____ AGE: _____
Last First MI
ADDRESS: _____
Street/Apt/No P.O. Boxes City State Zip
PHONE: (____) _____ CELL: (____) _____ SOCIAL SECURITY: _____
EMPLOYER: _____ OCCUPATION: _____
ADDRESS: _____ WORK PHONE: (____) _____

INSURANCE INFORMATION

<i>PATIENT RELATIONSHIP TO INSURED:</i>	<u>PRIMARY</u>	<u>SECONDARY</u>
	() SELF () SPOUSE () CHILD	() SELF () SPOUSE () CHILD

INSURANCE CO.:	_____	_____
ADDRESS:	_____	_____
PHONE NUMBER:	_____	_____
POLICYHOLDER'S NAME:	_____	_____
POLICY NUMBER:	_____	_____
GROUP/PLAN NUMBER:	_____	_____
COPAY AMOUNT:	_____	_____

WORKER'S COMPENSATION

MOTOR VEHICLE

INSURANCE CO.:	_____	_____
ADDRESS:	_____	_____
PHONE NUMBER:	_____	_____
FAX NUMBER:	_____	_____
CLAIM NUMBER:	_____	_____
ADJUSTER/CASE MANAGER:	_____	_____

MEDICAL RELEASE - PLEASE SIGN

I HEREBY AUTHORIZE ASSOCIATES IN REHABILITATION MEDICINE THE FILING OF INSURANCE AND RELEASE OF INFORMATION NECESSARY TO PROCESS MY CLAIM. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO ASSOCIATES IN REHABILITATION MEDICINE FOR SERVICES RENDERED. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL CO-PAYS, DEDUCTIBLES, AND CHARGES NOT PAID BY THE INSURANCE COMPANY. I ALSO AUTHORIZE ASSOCIATES IN REHABILITATION MEDICINE TO RELEASE ANY INFORMATION, INCLUDING DIAGNOSIS AND RECORDS OF TREATMENT OR EXAMINATION RENDERED TO ME TO ANY PHYSICIAN THAT MAY BE ACTIVELY PARTICIPATING IN MY CARE.

SIGNATURE _____

DATE _____