SPECIALISTS IN REHABILITATION MEDICINE, P.C.

WELCOME TO OUR OFFICE!

DATE: ________________

PATIENT INFORMATION

LAST NAME, FIRST NAME, MIDDLE INITIAL:		
ADDRESS:		
CITY, STATE, ZIP:		
CHECK BOX OF YOUR PREFERRED NUMBER		
☐ HOME PHONE: ( )		☐ MOBILE PHONE: ( )
GENDER: ☐ MALE ☐ FEMALE		Marital Status ☐ S ☐ M ☐ D ☐ W
DATE OF BIRTH:	AGE:	Reason for Treatment:

IN CASE OF EMERGENCY – WHOM SHOULD WE CONTACT?
NAME: ____ PHONE #: ____________________________
RELATIONSHIP: ______________________________________

Do you want Medical Health Record or Billing Information shared with this person? ☐ Yes ☐ No

DOCTOR INFORMATION

	REFFERING PHYSICIAN	PRIMARY CARE PHYSICIAN
NAME		
PHONE		

INSURANCE INFORMATION

	PRIMARY INSURANCE	SECONDARY INSURANCE
INSURANCE COMPANY NAME		
INSURANCE COMPANY PHONE #		
CONTRACT ID / MEMBER ID #		
GROUP #		
SUBSCRIBER'S DATE OF BIRTH		

IS THIS VISIT RELATED TO: ☐ WORK INJURY ☐ AUTO ACCIDENT ☐ N/A	
DATE OF INJURY:	LOCATION OF INJURY: (i.e. BACK, KNEE, ARM)
CLAIM NUMBER:	INSURANCE COMPANY NAME:
ADJUSTER'S NAME:	PHONE NUMBER: ( )
BILLING ADDRESS:	