PATIENT INFORMATION

PATIENT NAME_____ DOB_____

PATIENT SOCIAL SECURITY #_____PATIENT DIAGNOSIS_____

PARENT/GUARDIAN_____

ADDRESS_____CITY_____STATE_____ZIP_____

CELL PHONE_____HOME PHONE_____WORK PHONE_____

EMAIL_____

EMPLOYED BY_____

EMPLOYER ADDRESS_____PHONE_____

SPOUSE/EMPLOYED BY_____/_____

RESPONSIBLE PARTY/EMERGENCY CONTACT_____RELATION_____

ADDRESS_____CITY_____STATE_____ZIP_____

HOME PHONE_____WORK PHONE_____

POWER OF ATTORNEY/REPRESENTATIVE (IF APPLICABLE)_____

PERSON FINANCIALY RESPONSIBLE_____DOB_____ SS#_____

CONSENT FOR CARE/ASSIGNMENT OF BENEFITS

I certify that the above noted insurance carriers or payment sources are complete and correct as written.

I authorize Comprehensive Rehab to release information from my medical record as may be necessary for the completion of the clinic's claims for reimbursement to third party payers as needed for this or related claims. This authorization may include copies of my medical record to be sent to my insurance carrier.

In consideration of services received at Comprehensive Rehab, I hereby assign payment of medical benefits to Comprehensive Rehab. I agree to pay Comprehensive Rehab any and all charges that may exceed or that are not covered by my insurance coverage.

Signature of Patient,/Representative/Power of Attorney:_____Date:_____

Parent/Guardian Signature:_____Date:_____
(If patient is a minor)

HOW DID YOU HEAR ABOUT US?_____