

Rehabilitation Care Group, Inc.

Patient Information

Name _____
(First Name) (M/I) (Last Name)

Address _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Birthday _____ Soc Sec. Number ____/____/____

Sex: Male Female Marital Status: _____

Employer _____

Emergency Contact / Phone _____

Primary Care Physician _____

How did you hear about us? _____

Email Address _____

Responsible Party

Name _____
(First Name) (M/I) (Last Name)

Address _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Birthday _____ Soc Sec. Number ____/____/____

Relationship to Patient _____

Employer _____

Primary Insurance

Employer _____

Insurance Company _____

Insured ID _____ Policy Group _____

The Insured party is the patient

(Please continue if insured party is different than the patient)

Name _____
(First Name) (M/I) (Last Name)

Address _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Birthday _____ Soc Sec. Number ____/____/____

Relationship to Patient _____

Secondary Insurance

Employer _____

Insurance Company _____

Insured ID _____ Policy Group _____

The Insured party is the patient

(Please continue if insured party is different than the patient)

Name _____
(First Name) (M/I) (Last Name)

Address _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Birthday _____ Soc Sec. Number ____/____/____

Relationship to Patient _____

(Patient / Guardian Signature) (Date)

I hereby authorize direct payment of medical benefits to Rehabilitation Care Group for activities rendered by the employees. I understand that I am financially responsible for any balance not covered by insurance. I certify that all information is correct and authorize Rehabilitation Care Group to release any information for either medical care or in processing applications for financial benefits.