Registration Form for Outpatient Rehab

Patient Information

Patient name _____ Date of birth_____

Mailing address_____

City, State_____ Zip code_____

Preferred contact number(s) _____Alternate _____

Choose ***one*** method for appointment reminder: Call_____ Text_____ Email _____None_____

Email_____ Marital Status_____

Social Security number _____ Race _____

Employer _____ Work phone_____ Status: ☐PT/☐FT/☐UE/☐Disabled

Primary Care Physician _____

Emergency Contact Information

Full name_____

Relationship to patient_____

Phone Number _____ Alternate phone_____

Insurance Information- Complete if name of insured does *NOT* match patient

Policy holder's name_____

Social Security number_____ Date of birth_____

Relationship to patient_____ Employer_____

If Patient Is Under 18 Years of Age

Legal guardian's full name_____

Mailing address_____

City, State_____ Zip code_____

Home phone_____ Work or cell phone_____

Social Security number_____ Employer_____