Registration Form for Outpatient Rehab

Patient Information

Patient Name (First, MI, Last) ________________________________DOB ___________

Mailing Address (if different from license) ______________________________________

City, State ____________________________________ Zip Code _________________

Preferred Contact Phone numbers: ____

Choose one method for appointment reminder: Call _____ Text____ Email ____ None ___

Email: ______________________________ Marital Status: _______________________

Social Security Number ____________________ Employment Status________________

If Retired, date of retirement ________________

Employer _____________________________ Employer Phone Number _______________

Primary Care Physician: ____

Emergency Contact Information

Full Name ____

Relationship to Patient ______________________ Preferred Contact Number_____________

Insurance Information

Complete if name of insured does NOT match patient

Policy Holder's Name ____

Policy Holders' Date of Birth ____

Relationship to Patient ____

Employment Status: Full Time_____ Part Time ______ Self Employed ____ Unemployed ____

If Patient is under 18 years of age

Legal Guardian's full name ____

Mailing Address ____

City , State ____ Zip Code____________________

Preferred Contact Number ________________________ Social Security Number ___________

Employer ________________________ Employer Phone Number _______________________