Classic Rehabilitation, Inc.

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REGISTRATION FORM

Today's Date:	PCP:

PATIENT INFORMATION

Patient's last name: First:	Middle:	Marital status:

Is this your legal name? ◯ Yes ◯ No	If not, what is your legal name?	Former name:	Birth date:	Age: [Age]	Sex: ◯ M ◯ F

Address:

Social Security no.:	Home phone no.:	Cell phone no.:
Occupation:	Employer:	Employer phone no.:

EMAIL:

DATE OF INJURY:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Is this person a patient here?	◯ Yes ◯ No	Is this patient covered by insurance?	◯ Yes ◯ No
Occupation:	Employer:	Employer address:	Employer phone no.:

Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: Other(Relationship to subscriber):

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: Other [Relationship to subscriber]:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

INJURY INFORMATION

IS YOUR INJURY A RESULT OF : (CHECK ALL THAT APPLY)

WORK RELATED _______ ACCIDENT _______ OTHER _________

SURGERY: _______ yes _________ no If yes, Date of Surgery: _____________

AUTO ACCIDENT ONLY

Have you filed on your auto policy? _____ yes _____ no

Have you filed on any other party involved insurance? _____ yes _____ no

ATTORNEY PROTECT
ATTORNEY NAME:
ATTORNEY FIRM:
Address:
CITY/STATE/ZIP:
TELEPHONE:

WOMEN ONLY
Are you pregnant or is there any possibility you may be pregnant? _______ yes ________ no

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Windows User or insurance company to release any information required to process my claims.

____

Print Name

Patient/Guardian signature

Date