PATIENT INFORMATION FORM

Patient's name:_____ Date of birth:____/_____/____

Address:_____

_____

Phone number:_____ Cell Phone number _____

Social security #:_____ Email address _____

Health Insurance :

Primary

Medicare:_____ Medicaid:_____ Other:_____

ID Number:_____ Group#:_____

Business name:_____ Phone #:_____

Business address:_____

Secondary

ID Number:_____ Group#:_____

Nearest relative:_____ Phone number:_____

If this is a No-Fault claim, please check here:_____

If an attorney is involved, please furnish the following:
Name:_____ phone number:_____

I hereby give Crown Rehab permission to evaluate and treat me as is deemed medically necessary.
I authorize the release of any medical or other information necessary to process this claim.
I also request payment of government benefits either to myself or to the party who accepts assignment below.
I authorize payment of medical benefits to Crown Rehab for services rendered.
I understand that I am personally responsible for all charges and co-payments, whether or not paid by insurance, and for all services rendered on my behalf, or on the behalf of my dependents

Initial_____

Have you received any physical therapy this year at any other location? _____

Signed:_____ date_____