BARRINGTON REHABILITATION

PATIENT INFORMATION

Patient Name ______________________________ Birthdate ____/____/______
LAST FIRST MIDDLE INITIAL

Address ______________________________ City/State/Zip ______________________________

Home Ph ______________ Work Ph ______________ CellPh ______________

Patient SSN ______-______-________ Sex : M / F Student: Full / Part Time Marital Status: S / M / O

Patient's Employer ______________________________ Work Ph ______________

Employer Address ______________________________ City/State/Zip ______________________________

Emergency Contact ______________ Relationship ______________ Phone ______________

Physician ______________________________ Diagnosis ______________________________

Date of Injury ____/____/______ Date of Surgery ____/____/______ Date on Prescription ____/____/______

INSURED INFORMATION

Insured Name ______________________________ Birthdate ____/____/______
LAST FIRST MIDDLE INITIAL

Address ______________________________ City/State/Zip ______________________________

Home Ph ______________ Cell Ph ______________ Relationship: Self / Spouse / Parent

Insured SSN ____-____-____ Employer Name ______________________________ WorkPh ______________

Insured Employer Address ______________________________ City/State/Zip ______________________________

INSURANCE INFORMATION

Insurance Company ______________________________ PPO POS EPO HMO COBRA

ID# ______________ Group # ______________ Ph ______________

Medicare ID#: ______-______-______-____ Supplemental Insurance ______________________________

ID# ______________ Group # ______________ Ph ______________

Has patient had Home Health Care this year? YES / NO Discharge Date: ______________

Provider: ______________________________ Ph ______________

WORK COMP / AUTO / LIABILITY CLAIM INFO (*circle one*)

Claim # ______________________________ Insurance Carrier ______________________________

Adjustor Name ______________________________ Phone ______________________________

I authorize release of any information concerning my or my child's health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me to Barrington Rehabilitation. I understand I am responsible for any amounts insurance does not pay.

X ______________________________ Date ______________
Signature of patient or parent/guardian if minor

FOR OFFICE USE ONLY

Initial Visit ____/____/____ Frequency/Duration ______ wk/ ______ weeks Therapist ______________

Walk-In ______ Phone Call ______ Initials: ______ Account # ______________