Rehabilitation Physicians, PC

Relieving Pain and Restoring Lives

Patient Information

Account No: _____

Patient Name: _____

Mailing Address: _____

Home Phone: _____ Leave a Message: _____

Work Phone: _____ Social Security Number: _____

Date of Birth: _____ Marital Status: _____

Referring Physicians: _____

Address: _____

Phone: _____

Emergency Contact Name: _____ Phone Number: _____

Pharmacy Name: _____ Pharmacy Number: _____

Insurance Information

Primary Insurance: _____ Phone Number: _____

Subscriber Name: _____ Date of Birth: _____

Subscriber ID: _____ Group Number: _____

Date of Injury: _____

Secondary Insurance: _____ Phone Number: _____

Subscriber Name: _____ Date of Birth: _____

Subscriber ID: _____ Group Number: _____

Date of Injury: _____

Patient Insurance and Payment Responsibility

1. I authorize payment of my authorized benefits from my insurance carrier to be made on my behalf to Rehabilitation Physicians.
2. I authorize my holder of medical insurance information to release information to Rehabilitation Physicians to determine these benefits or the benefits payable to related services.
3. I understand that the ultimate responsibility for payment is mine should my insurance not reimburse Rehabilitation Physicians for service I received.

Signed: _____

Release Statement

1. I authorize Rehabilitation Physicians and his staff to perform diagnostic tests and provide necessary treatment necessary for medical evaluation and health care of the above mentioned patient.
2. I accept responsibility for all charges in the medical evaluation and health care of the above named patient.
3. I hereby give permission for Rehabilitation Physicians to provide relevant medical information about the above named patient.

Signed: _____