Patient Information

Patient Name:_____Today's Date:_____

Gender: M ☐ F ☐ Date of Birth _____ Age _____ Social Security # _____

Marital Status (check one): ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Name of Spouse/Parent/Guardian/Caregiver _____

Address _____

Home #_____Cell # _____ Email _____

May we call or leave messages for you at: **Home:** ☐YES ☐NO **Cell:** ☐YES ☐NO **Email:** ☐YES ☐NO

Emergency Contact: _____ Relationship _____

Emergency Contact Home # _____ Emergency Contact Cell # _____

Do we have permission to speak with your Emergency Contact about your medical condition, needs, & account? ☐ YES ☐ NO

Physician Information: Referring Physician _____ Phone_____

Address:_____

Primary Insurance Company: _____

ID# _____ Policy # _____Group # _____

Policy Holder's Name _____ Relationship to Patient _____ Date of Birth _____

Social Security # _____ Policy Holder's Employer: _____

Policy Holder's Address (if other than patient's): Address_____

Secondary Insurance Company: _____

ID# _____ Policy # _____Group # _____

Policy Holder's Name _____ Relationship to Patient _____ Date of Birth _____

Social Security # _____ Policy Holder's Employer: _____

Policy Holder's Address (if other than patient's): Address_____

Assignment of benefits/authorization to release information

I authorize payment of my insurance benefits directly to Advanced Neurologic Rehabilitation and authorize Advanced Neurologic Rehabilitation to disclose my protected health information to assist with the processing of my claim(s); carry out my treatment; and for health care operations like quality reviews. I understand I am personally responsible for balances not paid by my insurance.

x_____/_____/_____

Patient/Responsible Party Relationship to patient **Date**