Community Rehab of Greenville, Inc. DBA: Community Rehab Physical Therapy

PATIENT REGISTRATION INFORMATION

Name (Last) (First) (MI) Date of Birth Age Patient SS#

Address City State Zip Gender
_____Male _____Female

Home:(_____)_____ Work Phone:(____)_____ If condition is not related to an injury/Date of Onset:
accident, give **DATE OF ONSET**

Cell:(_____)_____ *E-mail address:_____ ____/____/____

Emergency Contact:
_____

Marital Status:
____Single ____Married ____Other

Home#:_____

Work#:_____

Employment Status:
_____Full-time _____Part-time
_____Retired _____Disabled
_____Self-Employed
_____Student

Relationship to Patient:
_____

If injury or accident, check type: Date of Injury or Accident
a: Work-related? (Current or Previous)
____Yes ____No _____/_____/_____
b: Auto Accident? If yes, State_____
____Yes ____No _____/_____/_____
c: Other Injury or Accident?
____Yes ____No _____/_____/_____
Describe:_____
_____

RESPONSIBLE PARTY BILLING INFORMATION

NOTE: IF PATIENT IS THE RESPONSIBLE PARTY, CHECK SELF AND SKIP TO NEXT SECTION

Responsible Party Name: Relationship to Patient: SS#: Date of Birth: Gender:
_____Check if SELF _____/_____/_____ ____M ____F

Responsible Party's Address City State Zip Code Daytime Phone Number
( )

EMPLOYMENT INFORMATION

Employer: (If self-employed, give name of your company) Employer Contact in case of questions about insurance:
Name: Phone: ( )

Employer Address: City State Zip Code If workers comp, what is your work status?

PRIMARY INSURANCE COVERAGE INFORMATION

Insurance Company #1: Policy/Subscriber ID/Comp Claim#: Group Number:

NOTE: IF PATIENT IS THE POLICYHOLDER, CHECK SELF AND SKIP TO NEXT SECTION

Policyholder (First,MI,Last) Patient's Relationship to Policyholder SS#: Date of Birth: Gender:
____Check if SELF ____/____/____ _ ___M ___F

Policyholder's Address (if different from patient) City State Zip Code

Employer Name/Address (for employer group insurance) City State Zip Code Employer Phone#:
( )

SECONDARY INSURANCE COVERAGE INFORMATION

Insurance Company #2: Policy/Subscriber ID: Group Number:

NOTE: IF PATIENT IS THE POLICYHOLDER, CHECK SELF AND SKIP TO NEXT SECTION

Policy holder (First,MI,Last) Patient's Relationship to Policyholder SS#: Date of Birth: Gender:
____Check if SELF ____/____/____ ___M ___F

Policyholder's Address (if different from patient) City State Zip Code

Employer Name/Address (for employer group insurance) City State Zip Code Employer Phone#:
( )

ATTORNEY INFORMATION (IF BILL NEEDS TO BE SENT TO ATTORNEY, COMPLETE THIS SECTION)

Attorney's Name: Law Firm Name: Attorney's Phone Number:
( )

Attorney's Address: City State Zip Code