APM&R
BRAIN • PAIN • SPORTS • SPINE

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Chart #_____
OFFICE USE ONLY

PATIENT INFORMATION AND INSURANCE FORM – PG 1/2

Today's Date ___ / ___ / ___

Name _____

Address _____

_____ Apt# _____

City _____ State_____ Zip_____

Home Phone (__ __ __) __ __ __ – __ __ __ __ Work Phone (__ __ __) __ __ __ – __ __ __ __

Cell Phone (__ __ __) __ __ __ – __ __ __ __ E-Mail _____

Patient Date of Birth ___ / ___ / ___ Social Security # __ __ __ – __ __ – __ __ __ __

Race:

☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other ☐ Two or More Races
☐ Refused to Report

Ethnicity:

☐ Hispanic ☐ Non-Hispanic or Latino
☐ Refused to Report

Preferred Language:

☐ English ☐ Spanish ☐ Indian ☐ Arabic ☐ Other ☐ Refuse to Report

Additional Contact Information

Phone Messages – Please check preferred number for our office to leave messages:

☐ Home ☐ Work ☐ Cell

Please check box with type of information that is acceptable to leave on phone message:

☐ Message of call only ☐ Test results ☐ Any other medical information

Do we have permission to speak to an immediate family member about your condition?

☐ Yes ☐ No

Emergency Contact Name_____

Emergency Contact Phone (__ __ __) __ __ __ – __ __ __ __

Referral Information

Who referred you to our office?

Name _____

– – please provide insurance information on next page – –

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Chart #_____
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PATIENT INFORMATION AND INSURANCE FORM – PG 2/2

Is this Worker's Compensation? ☐ Yes ☐ No

Is this related to an Automobile Accident? ☐ Yes ☐ No

If you answered yes to either of the above, please fill out information below. If you answered no, please fill out primary insurance coverage.

Date of Injury____ / ____ / ____ Claim # _____

Adjustor Name _____

Primary Insurance Coverage

Name of Insurance _____

Company Address _____

Company Phone # (__ __ __) __ __ __ – __ __ __ __

Subscriber's Name _____

Subscriber's Date of Birth ____ / ____ / ____ Subscriber's Relationship to Patient _____

Subscriber's Employer _____

Employer's Address _____

Phone # (__ __ __) __ __ __ – __ __ __ __

Contract # _____ Group # _____

Secondary Insurance Coverage

Name of Insurance _____

Company Address _____

Company Phone # (__ __ __) __ __ __ – __ __ __ __

Subscriber's Name _____

Subscriber's Date of Birth ____ / ____ / ____ Subscriber's Relationship to Patient _____

Subscriber's Employer _____

Employer's Address _____

Phone # (__ __ __) __ __ __ – __ __ __ __

Contract # _____ Group # _____

Who will be responsible for your balance after insurance pays?

Name _____

Address _____ Apt # _____

City _____ State _____ Zip _____

Phone (__ __ __) __ __ __ – __ __ __ __

AUTHORIZATION FOR DIRECT INSURANCE PAYMENT: I hereby authorize direct payment to Associates in Physical Medicine & Rehabilitation by the insurance carrier for services rendered to me. Regardless of whether or not direct payment is authorized, I understand that I am still financially responsible for any charges incurred until such time the account is settled.

Signed _____ Date _____