[ ] New patient
[ ] Update

For office use only: [ ] complete release
[ ] partial release

PATIENT INFORMATION SHEET

Patient Name:_____ **Date:**_____
MARITAL STATUS: [ ] Single [ ] Married [ ] Widowed [ ] Divorced [ ] Separated

Date of Birth:_____ **Age:**_____ **SS#:**_____
Height:_____ **Weight:**_____ **Male:**_____ **Female:**_____
Street Address:_____
City:_____ **State:**_____ **ZIP:**_____
E-Mail Address:_____
Home Phone:_____ **Work Phone:**_____ **ext.**_____ **Cell:**_____

Emergency Contact:_____**Phone number**_____
Relationship to patient:_____

EMPLOYMENT:
Patient's Employer:_____ Occupation:_____
Employer Address:_____
Spouse/Guardian Name:_____
Date of Birth:_____ **Work Phone:**_____
Employer Name:_____
Employer Address:_____

Medication Allergies:_____

Referring or Family Doctor:_____ **Phone:**_____
Address:_____

INSURANCE:
[ ] Commercial Ins [ ] Self Pay [ ] Worker's Compensation [ ] Medicaid/Medicare
We will need copies of all your insurance cards. **PLEASE PROVIDE CARD TO BE COPIED.**

Primary Insurance Company:_____
ID Number:_____ **Group Number**_____
Subscriber's Name:_____ **Date of Birth:**_____
Employer:_____

Secondary Insurance Company:_____
ID Number:_____ **Group Number:**_____
Subscriber's Name:_____ **Date of Birth:**_____
Employer:_____

Worker's Compensation: ***YES*** ***NO*** **circle one please**
Employer at Time of Accident:_____
Date of Injury:_____ **Claim#:**_____
Physician of Record:_____ **Phone:**_____
Case Worker:_____ **MCO:**_____

How did you hear about our practice:_____

Insurance Authorization & Assignment: I hereby authorize OHIO REHAB CENTER II, Inc. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physicians all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Date:_____ **Signature:**_____