

FOR INTERNAL USE ONLY

Dx: _____

Therapist: _____

Office Location: _____

PATIENT INFORMATION

Please Print

Date _____

PATIENTS NAME First _____ Middle Initial _____ Last _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE (_____) _____ WORK PHONE (_____) _____

CELL PHONE (_____) _____ EMAIL ADDRESS _____

SOCIAL SECURITY NUMBER _____ - _____ - _____ BIRTHDATE _____ AGE _____

SEX Male Female MARITAL STATUS Single Married Divorced Widowed Separated

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____ RELATIONSHIP _____

PATIENT OR PARENT EMPLOYED BY _____

EMPLOYER'S ADDRESS _____

CITY _____ STATE _____ ZIP _____

SPOUSE NAME _____ EMPLOYER _____

REFERRING PHYSICIAN _____ LAST MEDICAL APPOINTMENT _____ DATE OF INJURY OR ONSET OF SYMPTOMS _____

RECOMMENDED BY _____ MD FRIEND RADIO NEWSPAPER

IS YOUR CONDITION RELATED TO: employment auto accident other accident non-accident

IN CASE OF EMERGENCY CALL _____ RELATION _____ PHONE (_____) _____

TYPE OF INSURANCE No insurance (payment is due at time of service) Private Insurance Insurance pays _____ %

Auto Accident Worker's Comp Medicare Medicaid State _____

(If accident related, please also provide private health information, if available.)

Attorney name _____

Litigation Yes No Address _____

PRIMARY INSURANCE

SECONDARY INSURANCE

Name of insurer _____

Address _____

City, St Zip _____

Phone (_____) _____ (_____) _____

Insured's Name _____ Relation _____ Name _____ Relation _____

Insured's Birthdate _____ male female Birthdate _____ male female

ID/Group# _____ ID/Group# _____

ASSIGNMENT AND RELEASE I, the undersigned, have insurance coverage as listed above and assign directly to Prairie Rehabilitation Services all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Prairie Rehabilitation Services to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured _____ Date _____

MEDICARE AUTHORIZATION I authorize any holder of medical or other information about me to release to the Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated above or on the HCFA-1500 form, my signature authorizes release of the information to the insurer or agency shown.

Beneficiary Signature _____ Date _____