[ ] 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:**___________________________________