Rhode Island Rehabilitation

Today's Date:_____/_____/_____

Patient's Full Name:____

Address:_______________________________ City:_______________ State:_____ Zip Code:________

Home Phone:_________________ Cell Phone:_________________ Work Phone:_________________

Date of Birth:_____/_____/_____ Gender: M / F Minor: YES / NO

SSN(optional):____________ Email Address:_____________________________

Parent/Responsible Party/Insurance Subscriber, if different from above patient (CIRCLE all that apply)

Name:_____________________________________ Date of Birth:_____/_____/_____

Address:________________________________ City:______________ State:_____ Zip Code:________

Phone:_______________________________ Email Address:_________________________________

Insurance Information: (MUST BE COMPLETED ALONG WITH YOUR INSURANCE CARD)

Primary Insurance:________________________ Secondary Insurance:_________________________

Subscriber:__________________ DOB:_______ Subscriber:____________________ DOB:_________

InsuranceID #:___________________________ Insurance ID #:_______________________________

Group #: ________________________________ Group #: ___________________________________

Is your visit due to a motor vehicle accident? YES / NO Is this a work related injury YES / NO

Workers' Comp/Auto Insurance:___________________________

Adjuster:______________________Phone #: __________________ Claim #: ____________________

Date of Injury: _____/_____/_____

WORKERS' COMPENSATION ONLY

Place of Employment: _____________________________________ Phone #: ____________________

Work Address: __________________________ City:_______________ State:______ Zip Code: _______

ALL PATIENTS

Emergency Contact: ___________________________________ Phone #: ________________________

How did you hear about us? ____

I authorize the use of the above information on my insurance claims. I understand that my signature authorizes that payment be made and that my medical information may be released in order to pay my claim. **I understand that I am responsible for knowing my health insurance coverage.** I understand that I am responsible for any DEDUCTIBLE or CO-PAY amount designated by my insurance contract or for services denied by my insurance. I request that payment of authorized benefits be made on my behalf to Rhode Island Rehabilitation for any services rendered. I understand that I am responsible for any unpaid balance on my account. I permit a copy of this authorization to be used in place of the original.

Signature: ____ Date: _____/_____/_____

Signature of Patient, Guardian or Legal Representative