PATIENT INFORMATION SHEET Private Insurance/Work Comp/Personal Injury/Medicare

Patient Name: _____

Home Address: _____

City: _____ State: _____ Zipcode: _____

Date of Birth: ____/____/_____ Age: _____ Home Phone (____) ____ - _____
Home Phone (_____) _____ - _____ Cell Phone (____) ____ - _____
Social Security #: _____-_____-_____ Referring Physician: _____
Referring Physician Address: _____
Home Phone: (_____) _____ - _____ (Physician PIN#: _____)

Employer: _____
Address of Employer:_____
City: _____ State: _____ Zipcode: _____

Contact in case of Emergency: _____ Relationship: _____
Phone number (of emergency contact person): (_____) _____ - _____
Spouse: _____ Social Security #: (spouse): _____-_____-_____

Insurance Carrier: _____
Claims Mailing Address: _____
City: _____ State: _____ Zipcode: _____
Policy Number: _____ Group Number: _____
Adjuster: _____ Phone Number: (____) ____ - _____
Case Manager: _____ Phone Number: (____) ____ - _____
Primary Insured: (self, spouse, parent): _____

Secondary Insurance Carrier: _____
Claims Mailing Address: _____
City: _____ State: _____ Zipcode: _____
Policy Number: _____ Group Number: _____

Workers Compensation Claim Number/IPA Authorization #: _____
Date(s) of Injury (if applicable): _____
Location of Injury: (if applicable): _____ Date last worked: _____
Attorney Name: _____ Phone Number: (____) ____ - _____
Attorney Address: _____

Assignment of Benefits: I hereby authorize all payment which I am entitled to for the medical treatment and services, including major medical and supplemental benefits relative to the services reported to the physician or medical group, California Rehabilitation, Inc. I understand visit and procedure fees are available upon request. I understand that I am financially responsible to said medical clinic for charges not covered by this assignment. I understand that procedure reports and evaluation reports may accompany routine billing procedures and I authorize release of all information which is requested by the insurance company concerning my treatment, illness or injury.

Date: ____/_____/_____ Patient's Signature _____

If you have insurance cards, please let us copy them