



**REHABILITATION DEPARTMENT  
OUTPATIENT REGISTRATION FORM**

PATIENT NAME: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELL: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ IF MINOR, PARENT'S SS# \_\_\_\_\_

IN CASE OF EMERGENCY: \_\_\_\_\_ PHONE: \_\_\_\_\_

E-MAIL: \_\_\_\_\_ *(Use for Health Related Newsletter)*

**INSURANCE INFORMATION-Please provide your insurance card(s with this form, and/or complete below:**

Subscriber Name: \_\_\_\_\_ Subscriber SS# \_\_\_\_\_

Subscriber Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Subscriber Employer: \_\_\_\_\_

Name of Insurance \_\_\_\_\_ Co-Pay Amount \_\_\_\_\_

Address \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**MEDICARE PATIENTS: Are you currently enrolled in Home Health?** *Check one*  Yes  No

If Yes: (List Company Name) \_\_\_\_\_

**AUTO ACCIDENT**

If you want us to bill for an auto accident, we will do so. We ask that you present us with your private health insurance information as backup. I do not wish to provide a copy of my private health insurance card. I realize that if my auto benefits should be denied or exhausted that I would be responsible for any charges incurred.