Hands On Hands Rehabilitation Center, Inc.

REGISTRATION FORM

(please print)

Today's Date:	Diagnosis & Date of Injury/Surgery:

PATIENT INFORMATION

First:	Last:	MI:	☐ M ☐ F	Telephone #: ( )
Street Address:	City, State	Zip Code:		Cell #: ( )
Date of Birth	CA License	SS#:	Email Address: (would you like to receive our newsletters?):	
Employer Name/Address:				Telephone Number: ( )

PHYSICIAN INFORMATION

Physician's Name:	Telephone # ( )	FAX # ( )
Street Address:	City, State	

PRIVATE INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Please indicate primary Insurance: ☐ Blue Shield ☐ Blue Cross ☐ United Healthcare ☐ Aetna ☐ Other:

Insurance Phone # ( )	Insurance Policy #	ID #

Who is responsible for this bill?____________________________

Did you sustain an injury at work?	Y	N	Are you covered under an employer or union policy?	Y	N
Are your injuries accident related?	Y	N	Is your spouse or other family member employed?	Y	N
Are you currently employed?	Y	N	Do you have a secondary insurance policy?	Y	N
Have you ever served in the military?	Y	N	Are you covered under any other healthcare plan?	Y	N
Are you receiving home health services?	Y	N			

IN CASE OF EMERGENCY

Name of local friend or relative(not living with you):	Relationship	Home Phone #: ( )	Cell Phone #: ( )

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any and all professional services rendered. I have read all the information on this sheet and have completed the above answers, I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information. I authorize my insurance benefits to be paid directly to Hands On Hands Rehab Center, Inc. I also authorize Hands On Hands Rehabilitation Center, Inc. or my insurance company to release any information required to process my claims.

Do you have an Advance Health Care Directive? Yes No. (your right to decide instructions for your health care)
Would you like to get one? Yes No

Patient / Guardian Signature____***Date:***_________________

WORKERS' COMPENSATION INSURANCE INFORMATION

(For office Use Only)

W/C Insurance Company:	Address:	Telephone #: ( )
Claim Number:	Adjuster:	FAX #: ( )
Comments:		