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.

Patient / Guardian Signature_____***Date:***_____

WORKERS' COMPENSATION INSURANCE INFORMATION

(For office Use Only)

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