Document Category: Organizational Form

Visit

Date of Service:________________Diagnosis:__________________________________ Recurring: ☐Yes ☐No

Service: ☐PT ☐OT ☐Speech Location: ☐ MHUC ☐ YMCA ☐ Mill Valley ☐ Plain City

Attending Physician: _____________________________________ Family Physician:_________________________

Patient Information

Patient's Name (Last, First, MI):____ DOB: ____________________

Address: ____ PO Box/Apt#:_________

City: __________________________State: ______ Zip Code: _____________ County: _______________________

Telephone Number: (H)_______________________ (C)______________________ (W)___________________

Email Address: ____ @ _____________________________________

Maiden Name: _________________________ Social Security Number: ______________ Sex: ☐Female ☐Male

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Legally Separated ☐Life Partner Veteran: ☐Yes ☐No

Retired? ☐Yes, Date_________________ Patient's Occupation: ____

Employer Name: ____ Telephone Number: (_____)_______________

Employer's Address: ____

Race: ☐American Indian/Alaska Native ☐Asian/Oriental ☐African American/Black ☐Caucasian/White ☐Hispanic/Latino ☐Middle Eastern/Indian ☐Native Hawaiian/Pacific Islander ☐Other ☐Two or More Races ☐Decline to Answer

Emergency Contact

Emergency Contact (not living in same household): _______________________________________ DOB:____________

Address: _______________________________________ City/State:_____________________ Zip Code:________

Relationship: _________________________________Telephone Number: (_______)________________________

Guarantor Information

Guarantor Name:____ Telephone Number: (______)_______________

Guarantor Address:____

City:__________________________________ State:____________________ Zip Code:____________________

DOB:_______________SS#______________________ Employer:_______________________________________

Primary Insurance

Primary Insurance: ___________________________________ ID#:__________________ Group#:____________

Claim Mailing Address:____

Policyholder's Name: ___________________________________ DOB:____________SS#:__________________

Secondary Insurance

Secondary Insurance: __________________________________ ID #:____________________ Group#:___________

Claim Mailing Address:____

Policyholder's Name: ______________________________________ DOB:____________SS#:__________________

Misc.

Is this visit due to a work related injury? ☐Yes ☐No If yes, date of injury:_______________________________

Is this visit due to a motor vehicle accident? ☐Yes ☐No If yes, date of accident:___________________________

*Please attach a copy of the insurance cards; both front and back of the cards. If Worker's Compensation, a copy of the BWC card.

REHAB SERVICES REGISTRATION INFORMATION