

Spartanburg Regional Rehabilitation Services - Adult

PATIENT INFORMATION		PRIMARY INSURANCE INFORMATION		
NAME (FIRST,MIDDLE,LAST)		INSURANCE COMPANY NAME		
SS#	DATE OF BIRTH	INSURANCE COMPANY MAILING ADDRESS		
STREET ADDRESS		CITY, STATE & ZIP		
MAILING ADDRESS (IF DIFFERENT)	COUNTY	EFFECTIVE DATE		
CITY & STATE	ZIP	POLICY & GROUP #		
PRIMARY POLICYHOLDER'S INFORMATION				
SEX:	RACE:	MARITAL STATUS:		
POLICY HOLDER'S NAME		RELATIONSHIP TO PATIENT		
EMPLOYMENT STATUS		MAILING ADDRESS (IF DIFFERENT)		
<input type="checkbox"/> EMPLOYED <input type="checkbox"/> RETIRED <input type="checkbox"/> DISABLED <input type="checkbox"/> STUDENT <input type="checkbox"/> OTHER		POLICY HOLDER'S EMPLOYER		
EMPLOYER NAME	PHONE	EMPLOYER ADDRESS		
OCCUPATION	EMPLOYER PHONE #			
EMPLOYER ADDRESS	PHONE	<th style="text-align: center;">SECONDARY INSURANCE/POLICY HOLDER'S INFO</th>		SECONDARY INSURANCE/POLICY HOLDER'S INFO
CITY, STATE & ZIP	INSURANCE COMPANY NAME			
RELATIVE INFORMATION		POLICY & GROUP #		
NAME	DATE OF BIRTH	POLICY HOLDER'S NAME	RELATIONSHIP TO PT	
RELATION TO PATIENT:	<input type="checkbox"/> PARENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER			
STREET ADDRESS		<th style="text-align: center;">WERE YOU INJURED IN AN ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO</th>		WERE YOU INJURED IN AN ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
CITY, STATE, & ZIP		IF YES: <input type="checkbox"/> AT WORK <input type="checkbox"/> AUTO ACCIDENT <input type="checkbox"/> RECREATIONAL <input type="checkbox"/> OTHER _____		
SS#	EMPLOYER	DATE OF INJURY:	TYPE OF INJURY:	
HOME PHONE #	WORK PHONE #	<th style="text-align: center;">WORKERS COMPENSATION INFORMATION</th>		WORKERS COMPENSATION INFORMATION
EMERGENCY CONTACT		CURRENT WORKING STATUS: <input type="checkbox"/> LIGHT DUTY <input type="checkbox"/> REGULAR DUTY <input type="checkbox"/> MEDICAL LEAVE		
NAME	RELATIONSHIP	ADJUSTOR:	PHONE:	
HOME PHONE #:	WORK PHONE #:	DATE OF INJURY:	CLAIM #	
REFERRING PHYSICIAN INFORMATION				
PHYSICIAN NAME:		PHYSICIAN PHONE:		
HOME HEALTH SERVICES				
HAVE YOU/PATIENT RECEIVED HOME HEALTH SERVICES IN THE PAST 120 DAYS? <input type="checkbox"/> YES <input type="checkbox"/> NO				
PREFERRED METHOD OF CONTACT				
How would you like to be contacted regarding appointments, treatment and/or other information pertinent to your healthcare healthcare? Okay to leave message on voice mail? <input type="checkbox"/> Y <input type="checkbox"/> N (PLEASE CHECK ONE)				
ANY METHOD:	HOME PHONE:	WORK PHONE:	CELL PHONE:	
RELEASE OF MEDICAL INFORMATION				
I AUTHORIZE THE PERSON(S)/PHYSICIAN(S)/AGENCY(S) LISTED BELOW TO RECEIVE ALL HEALTH INFORMATION REGARDING TREATMENT &/OR OTHER INFORMATION PERTINENT TO MY HEALTHCARE PROVIDED AT <i>Regional Rehabilitation Services</i>				
NAME/PHYSICIAN/AGENCY	PHONE:	NAME/PHYSICIAN/AGENCY	PHONE:	
I DO NOT AUTHORIZE ANY INFORMATION TO BE DISCLOSED TO ANY OTHER PARTIES EXCEPT TO ME AS THE PATIENT/GUARDIAN.				
INITIAL HERE				
PATIENT/GUARDIAN SIGNATURE		DATE		