

Spartanburg Regional Rehabilitation Services - Pediatrics

PATIENT INFORMATION				PRIMARY INSURANCE INFORMATION			
NAME (FIRST,MIDDLE,LAST)				INSURANCE COMPANY NAME			
SS#				INSURANCE COMPANY MAILING ADDRESS			
STREET ADDRESS				CITY, STATE & ZIP			
MAILING ADDRESS		COUNTY		EFFECTIVE DATE			
CITY & STATE		ZIP		POLICY & GROUP #			
PHONE		CELL PHONE		PRIMARY POLICYHOLDER'S INFORMATION			
DATE OF BIRTH				POLICY HOLDER'S NAME & RELATIONSHIP TO PT.			
SEX: RACE:				SOCIAL SECURITY #			
PARENT'S INFORMATION				MAILING ADDRESS (IF DIFFERENT)			
FATHER'S NAME				POLICY HOLDER'S EMPLOYER			
FATHER'S DOB				EMPLOYER ADDRESS			
FATHER'S SOCIAL SECURITY #				EMPLOYER PHONE #			
MOTHER'S NAME				SECONDARY INSURANCE/POLICY HOLDER'S INFO			
MOTHER'S DOB				INSURANCE COMPANY NAME			
MOTHER'S SOCIAL SECURITY #				INSURANCE COMPANY MAILING ADDRESS			
PERSON RESPONSIBLE FOR BILL/GUARANTOR				POLICY & GROUP #			
NAME				POLICY HOLDER'S NAME & RELATIONSHIP TO PT			
SS#				SOCIAL SECURITY #			
STREET ADDRESS				MAILING ADDRESS (IF DIFFERENT)			
CITY & STATE				REFERRING PHYSICIAN INFORMATION			
ZIP				REFERRING PHYSICIAN			
PHONE #		CELL PHONE		PHONE NUMBER			
EMERGENCY CONTACT							
NAME				HOME PHONE #:			
RELATIONSHIP				WORK PHONE #:			
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 voicemail? <input type="checkbox"/> Y <input type="checkbox"/> N (PLEASE CHECK ONE)							
ANY METHOD:		HOME PHONE:		WORK PHONE:		CELL PHONE:	
MEDICAL RECORD RELEASE							
I AUTHORIZE THE PERSON(S)/PHYSICIAN(S)/AGENCY(S) LISTED BELOW TO RECEIVE ALL HEALTH INFORMATION ABOUT TREATMENT &/or OTHER INFORMATION PERTINENT TO MY/MY CHILD'S HEALTHCARE PROVIDED AT <i>Regional Rehabilitation Services</i>							
NAME/PHYSICIAN/AGENCY		PHONE:		NAME/PHYSICIAN/AGENCY		PHONE:	
NAME/PHYSICIAN/AGENCY		PHONE:		NAME/PHYSICIAN/AGENCY		PHONE:	
<input type="checkbox"/> 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	