AVALON REHAB PATIENT REGISTRATION FORM

Date:_____

Name:_____
(last) (first) (m.i.) (suffix)_____

Birth Date: _____ **Sex**: M / F **SSN**: _____

Home Address: _____
(street) (city) (state) (zip) _____

Drivers License: _____

Phone: _____
(home) (work) (cell)

How do you prefer to receive your statements: □ eMail □ Fax □ Postal Mail

eMail: _____ Fax: ( ) _____

Employer: _____ Occupation: _____

Address: _____ Phone: ( ) _____

Referring Physician (if applicable):_____ Phone: ( ) _____

Who may we thank for your referral other than your Doctor? _____

Marital Status: Single / Married / Divorced / Widowed / Separated / Domestic Partner / Minor Child

Name of Spouse:_____ Age: _____ Birth Date:_____

Employer:_____Occupation:_____ Phone: ( ) _____

Address: _____
(street) (city) (state) (zip) _____

Emergency Contact: _____ Relationship: _____

Phone: ( )_____

Closest relative other than Spouse (in case of emergency):_____

Address:_____
(street) (city) (state) (zip)

Phone: ( )_____

INSURANCE INFORMATION (Please Complete)

Primary Insurance: _____ Policy Number: _____

Insured Name: _____SSN: _____D.O.B. _____

Secondary Insurance:_____Policy Number: _____ _____

Insured Name: _____SSN: _____D.O.B. _____

All professional services are the ultimate responsibility of the patient.

X _____

Signature - Patient or Representative Date