

Columbia Rehabilitation Clinic, Inc.
PATIENT INFORMATION

Today's Date _____ Patient Account # _____
Name (last, first, middle) _____ Home Phone # _____
Street Address _____ City _____ State _____ Zip _____
Birthdate _____ Male ___ Female ___ Married ___ Single ___ Divorced ___
Drivers License # _____ State _____ Social Security # _____
Emergency contact not living with you _____ Relation _____
Street Address _____ City _____ Zip _____ Phone _____
If patient is a student, Full time Part Time School _____
Your Employer _____ Phone _____
Street Address _____ City _____ Zip _____
Referring Doctor _____
Is problem result of an accident _____ Date _____ Auto ___ Work Related ___
When/How did problem start _____
Describe physical problem (If surgery, give date) _____
Have you received Home Health Care Yes No Dates: From _____ to _____
Previous therapy for this problem _____
What medications do you take & when _____
List other health problems (heart problems, pregnancy, high blood pressure, metal implants, etc.) _____

Primary Insurance _____ Policy ID# _____
Policyholder's Name _____ Birth Date _____ Relationship to Patient _____
Policyholder's Address _____ City _____ State _____ Zip _____
Policyholder's Employer _____ Policyholder's Social Sec. # _____

Secondary Insurance _____ Policy ID# _____
Policyholder's Name _____ Birth Date _____ Relationship to Patient _____
Policyholder's Address _____ City _____ State _____ Zip _____
Policyholder's Employer _____ Policyholder's Social Sec. # _____

Do you have an attorney Yes No **Attorney's Name & Address** _____

Is this a Worker's Compensation Injury Yes No Date of injury ___/___/___ Claim # _____

Workers Compensation Insurance Carrier _____

Address _____ Person to contact _____ Phone _____