Columbia Rehabilitation Clinic, Inc.

PATIENT INFORMATION

Email Address: _____

Today's Date _____ Home Phone # _____

Name (last, first, middle)_____Cell Phone #_____

Street Address _____ City _____ State _____ Zip _____

Birthdate _____ Male ____ Female ____ Married ____ Single ____ Divorced ____ Widowed ____

Drivers License #_____ State _____ Social Security # _____

Emergency contact _____ Relation _____ Home Phone # _____

Street Address _____ City _____ Zip _____ Cell Phone # _____

If patient is a student, Full time ❑ Part Time ❑ School _____

Your Employer _____ Phone # _____

Street Address _____ City _____ Zip _____

Referring Doctor _____ Primary Care 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 # _____