RainRehab.com

RAINBOW REHAB
PHYSICAL & OCCUPATIONAL THERAPY
HAND REHABILITATION

REGISTRATION INFORMATION FORM

Date: _____ Patient's Name: _____ Date of Birth: _____

Home Phone #: _____ Cell Phone #: _____

Address: _____
street city state zip

Social Security #: _____ Email address: _____

Sex : ☐ Male ☐ Female | ☐ Single ☐ Married ☐ Widowed ☐ Separated
☐ Employed ☐ Self-Employed ☐ Full-Time Student ☐ Part-Time Student

Emergency Contact (Name): _____ Relationship: _____

Phone #: _____ Email address: _____

Referring Physician: _____ Primary Physician: _____

Address: _____ Address: _____

_____ _____

Phone #: _____ Phone #: _____

Insured's Name: _____ Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other

Address: _____
street city state zip

Social Security #:_____ Date of Birth:_____ Sex : ☐ Male ☐ Female

Phone #: _____

PRIMARY INSURANCE INFORMATION:

Insurance Co: _____

Phone #: _____

ID/Claim #: _____

Group #: _____

SECONDARY INSURANCE INFORMATION:

Insurance Co: _____

Phone #: _____

ID/Claim #: _____

Group #: _____

Employer:_____ Work Phone#:_____

Address: _____

Have you received therapy at another facility? Y / N

If yes, please explain where, when, how many visits and for what injury? _____

_____

Is this injury post-surgical? Y / N Is your injury a result of motor vehicle accident? Y / N Date of Accident_____

Adjuster's name:_____ Phone#_____

Is your injury a result of a work-related accident? Y / N Date of Injury_____

Is your injury a result of a slip and fall accident? Y / N Is your injury a result of any other type of accident? Y / N

Do you have an attorney? Y / N Attorney's name: _____ Phone #: _____

Address: _____

If you answered yes to any of the above questions, additional supporting documentation may be requested.

Please list other doctors you have seen for the condition you are being treated for at Rainbow Rehab, LLC:

_____

Who may we thank for referring you to Rainbow Rehab, LLC: _____