ABSOLUTE HEALTHCARE AND REHAB CENTER

PERSONAL INFORMATION

Name: _____ Social Security # _____-_____-_____

Address: _____ City: _____State: _____ Zip: _____

Home Phone: (___)_____. Birth Date: _____Age:____ Sex: ☐ M ☐ F

Cell Phone: (___)_____ ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Driver's License No. _____ State_____ Expires_____

Employer Name: _____ Work Phone: (___)_____.

Address: _____ City: _____State: _____ Zip:_____

Name of Spouse: _____ Spouse's Social Security # _____-_____-_____

Spouse's Employer Name: _____ Work Phone: (___)_____

Address: _____ City: _____State: _____ Zip: _____

Name of Emergency Contact: _____

Relationship: _____Phone # _____

INSURANCE INFORMATION (Please submit your card(s) and drivers license to be copied)

PRIMARY MEDICAL

Insurance Co:_____

Policy Number:_____ Group Number: _____

Policy Holder:_____ Policy Holders Social Security # _____-_____-_____

Policy Holders Employer_____

SECONDARY MEDICAL

Insurance Co:_____

Policy Number:_____ Group Number: _____

Policy Holder:_____ Policy Holders Social Security # _____-_____-_____

Policy Holders Employer_____

IF THIS WAS DUE TO AN AUTO ACCIDENT

Auto Insurance Carrier:_____ Policy Number: _____

Attorney Firm: _____ Contact Name _____

Address: _____

City: _____State: _____ Zip: _____ Phone: (___)_____.

Assignment of Benefit/Consent for Treatment: I do hereby assign all medical and/or chiropractic benefits to which I am entitled, including all government and private insurance plans to this office. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for all my charges not paid by my insurance. I authorize this office to release all information necessary to secure payment, transmit and process claims electronically or through any other reasonable and customary means; to any insurance company, adjuster or attorney. I hereby voluntarily consent to my treatment at this office and authorize such treatments, examinations, medications and diagnostic procedures (including but not limited to the use of lab and radiographic studies) as ordered by my attending doctor. I have read this consent, am aware of its contents and fully understand the same. I acknowledge that no assurance or promises have been given to me concerning the results, which may be obtained by such treatments and procedures hereby, affirmed by the signature of the undersigned.

PATIENT SIGNATURE: _____ **DATE:**_____

GUARDIAN SIGNATURE: _____ **DATE:** _____