Marsh Brook Rehab

PATIENT REGISTRATION FORM

Last Name:	First Name:	M.I.:
Street Address:	P.O. Box (if applicable)	
City:	State:	Zip:
Home Telephone:	Cell Phone:	
Date of Birth: (mm/dd/yyyy):	Marital Status: ☐ Single ☐ Married ☐ Other ☐ Student	Sex: M_____ F_____
If minor, parent/guardian:		
Employer	Work Telephone:	
Referring Physician	Telephone:	
Primary Care Physician:	Telephone:	
Date of Injury or Onset of current episode/illness:		

PRIMARY MEDICAL INSURANCE INFORMATION

Please check one below:

☐ Workers' Compensation ☐ Motor Vehicle Accident State: _____ ☐ Health Insurance ☐ Self

(For workers' compensation and motor vehicle claims, please complete the appropriate information. We also need your health insurance information as many insurance companies require authorizations to be obtained even though we are not billing them)

Health Insurance Company:	Telephone:
Insurance ID Number:	Insurance Group Number:
** Subscriber's Name	Date of Birth:
Relationship to Patient:	
Subscriber's Employer:	

** If you have this policy through your spouse, parents or other sources, he or she will be the subscriber of your insurance policy.

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Workers' Compensation Information

If this is a work-related injury, please complete the information below.

- Date of Injury: _________________
- State where injury occurred: ________________________
- Employer Workers' Compensation Carrier information:

Insurance Name: ____________________

Address: ____________________ P.O Box: ____________________

City: ____________________ State: __________ Zip Code: __________

Telephone Number: ____________________

Adjustor: ____________________

File Claim Number: ____________________

Motor Vehicle Information

If this is a motor vehicle related injury, please complete the information below.

- Date of Injury: _________________
- State where injury occurred: ________________________
- Auto Insurance information:

Your Auto Insurance Name:: ____________________

Address: ____________________ P.O Box: ____________________

City: ____________________ State: __________ Zip Code: __________

Telephone Number: ____________________

Medical Payments Representative: ____________________

File Claim Number: ____________________

**** If someone else was responsible for the motor vehicle accident, please complete below.**

Responsible Party's Auto Insurance Name:: ____________________

Address: ____________________ P.O Box: ____________________

City: ____________________ State: __________ Zip Code: __________

Telephone Number: ____________________

Claim Representative: ____________________

File Claim Number: ____________________