parkview
MEDICAL CENTER

PATIENT INFORMATION:

Name_____ Birth Date_____ Age_____ Sex _____Marital Status_____

Address_____ City/State_____Zip_____ Phone_____

Soc. Sec. #:_____ Family/Primary Doctor_____ Cell Phone _____

Employer_____Phone_____Occupation_____

Address_____ City/State _____ Zip_____ Status (Circle One) FT PT

Next of Kin_____ Relationship_____ Home Phone_____

Work Phone_____ Address_____ City/State_____ Zip_____

SUBSCRIBER AND/OR GUARANTOR INFORMATION:

Name_____ Phone_____

Address_____ City/State_____ Zip_____

Soc. Sec # _____Birth Date _____Relationship to Patient_____

Employer_____ Phone_____ Occupation_____

Address_____ City/State _____ Zip_____ Status (Circle One) FT PT

INSURANCE INFORMATION:

PRIVATE INSURANCE & MEDICAID ONLY: ☐ **PRIMARY** ☐ **SECONDARY**

Company_____ Phone/Fax _____Policy #_____Grp#_____

Subscriber_____ Authorization No._____ #of Visits_____ Date Range_____

PRIVATE INSURANCE & MEDICAID ONLY: ☐ **PRIMARY** ☐ **SECONDARY**

Company_____ Phone/Fax _____Policy #_____Grp#_____

Subscriber_____ Authorization No._____ #of Visits_____ Date Range_____

MEDICARE ONLY:

☐ **PRIMARY** ☐ **SECONDARY** Medicare Number_____ **Home Care Srv? _____**

Are you or your spouse currently employed? _____

If so, are you covered under your spouse's health insurance plan? _____

If retired, please list date of retirement _____

Are you entitled to Black Lung Benefits? _____

Are you entitled to VA Benefits?_____ If so, has the VA agreed to pay for Outpatient Rehabilitation services? _____

Is this a work related injury/illness/or auto accident? _____

Have you received a kidney transplant? _____ If so, list date_____

Have you received dialysis treatments? _____ If yes, beginning date_____

Did you receive your Medicare benefits due to:

(Please Circle One) Retirement age Disability Renal Disease VA Benefits Federal Black Lung Benefits

Referral Taken By_____ Schedule: Date____/____ Time____/_____ Discipline___/___ Therapist_____/_____

PARKVIEW MEDICAL CENTER REHAB SERVICES OUTPATIENT REFERRAL/REGISTRATION FORM