A.R.I.
ADVANTAGE REHAB INC.

REGISTRATION (PLEASE PRINT)

PATIENT INFORMATION

Home Phone: _____ **Cell #:**_____

(check mark next to the primary phone number)

Name:_____ **SS#**_____
Last Name First Name Initial

Address:_____

City:_____ **State:**_____ **Zip:**_____

__ Single __Married __Widowed __Divorced Sex: M / F Birth Date:_____

Primary Insurance:_____ **Secondary Insurance:**_____

If filling for a minor: Person responsible for the account?_____

Date of Birth:_____ Address if different from above:_____

SS#_____

If this is under *workers compensation*, the following MUST be filled out

Employed By:_____ Occupation:_____

Business Address:_____ Phone:_____

In case of an emergency, who should be notified? Name:_____

Relationship to Patient:_____ **Phone:**_____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage as stated above. I assign directly to Advantage Rehab, Inc insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid for by insurance.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____
Respon**sible Party Signature** **Today's Date**