Personal Information

Patient's Name (include middle initial):_____

Patient's Social Security Number:_____--_____--_____ Age:_____

Gender:_____ Date of Birth:_____/_____/_____

Address: Street_____

City_____State_____Zip_____

Home Phone: ( )_____--_____ Mobile Phone: ( )_____--_____

Work Phone: ( )_____--_____ Extension: _____ Work Hours: _____

Which of these numbers is BEST to reach you at? _____

Permission to leave personal health information on voicemail? Yes / No

_____

If you have a lawyer involved in this case:

Lawyer/Firm Name:_____Phone: ( )_____

Address: Street_____City_____

State:_____ Zip:_____

Insurance and Health Care Provider Information:

Primary Insurance Company: _____

Secondary Insurance Company: _____

Auto Insurance Company (if applicable): _____ Claim #: _____

Date of Loss: _____ Adjuster: _____ Phone: ( )_____--_____

Worker's Compensation Insurance Company (if applicable): _____

Claim # : _____ Adjuster: _____ Phone: ( )_____--_____

_____

Cancellation Policy

We ask that you please give at least 24 hours' notice when cancelling or rescheduling appointments. **Failure to cancel your appointment without giving 24 hours' notice may result in a $25.00 fee at the responsibility of the patient.** Fort Washington Rehabilitation & Fitness Center also reserves the right to terminate the treatment of patients who have chronic cancellations.