Patient Personal Information

Date: _____

Patient Information

Patient Name		Home Phone	Cell Phone	
Address		**City**	**State**	**Zip**
Marital Status	**Spouse Name**	**SS#/DOB**	**Email Address**	

Is this Visit a Result of an injury at work? If yes, please fill out below.

Employer Name	Contact Person	Phone Number		
Address		**City**	**State**	**Zip**

Primary Care Physician Information

Primary Care Physician	Phone

Emergency Contact Information – Not living at the same address

Name	Relationship	Contact Number

Insured Information if not Patient

Insured Name	DOB	Phone Number
Relationship	**Address (if different from patient)**	

Assignment of Benefits:

I directly assign all my benefits, including major medical benefits and Medicare, to Pro Fit Rehab of Charlotte, PA. I understand that this authorization for assignment remains in effect until I revoke it in writing. A photocopy of this assignment will be considered as valid as this original assignment. I further understand that I am responsible for all incurred charges.

Authorization to Receive Therapy:
I hereby authorize treatment to be rendered by Pro Fit Rehab of Charlotte, PA as prescribed by my physician.

Authorization to Release Information:
I hereby authorize the release of any medical information necessary to process insurance claims and any holder of medical information about me to release any such information needed to determine these benefits or the benefits payable for related services.

BY VIRTUE OF MY SIGNATURE, I have read and agree to the above acknowledgment/authorizations.

Insured or Guardian's Signature_____ **Date:**_____