APPLE REHAB
Sport & Spa

# Patient Information

Please fill out section A completely

SECTION A

_____ _____ _____ _____-____-_____
(Last Name) (First Name) (MI) (Social Security #)

_____ _____ _____ _____
(Home address, **No rural route/P.O. Boxes)** (City) (State) (Zip code)

_____ _____ _____ _____
(Date of birth) (Home Phone#) (Work phone #) (Cell Phone #)

_____ _____ _____ _____
(Age) (Marital Status) (Spouse's full name) (Referring Physician)

_____ _____
(Employer) (Employer Address, city, zip code)

_____ Is this work-related? **Y / N** Has it been reported at work? **Y / N**
(Date of Injury)

_____ _____
(Contact person- WC Claims) (Claim #)

How did you hear about our Facility? _____

**IF LEGAL ACTION IS INVOLVED WITH THIS INJURY, PLEASE LIST ATTORNEY, COMPLETE ADDRESS, & TELEPHONE #:**

_____

_____

_____

**Phone #:**_____

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**Worker's Compensation Insurance Information**

PLEASE LIST THE NAME & COMPLETE BILLING ADDRESS OF THE INSURANCE WE WILL SEND CLAIMS TO:

_____

_____

_____

**PLEASE FILL OUT THE BACK OF THIS SHEET ALSO**

PERSONAL INSURANCE -PRIMARY

_____ _____
(Company Name) (Address, City State, Zip Code)

Policyholder Name: _____ _____ _____
(First) (M.I.) (Last)

Policyholders Social Security #:_____-_____-_____ _____ _____
(Group #) (Policy#)

PERSONAL INSURANCE-SECONDARY

_____ _____
(Company Name) (Address, City State, Zip Code)

Policyholder Name: _____ _____ _____
(First) (M.I.) (Last)

Policyholders Social Security #:_____-_____-_____ _____ _____
(Group #) (Policy#)

**ASSIGNMENT OF BENEFTIS**

**I understand that I am financially responsible for all services rendered by Apple Rehab Sport & Spa, Leslie Weissman . As a courtesy to the patient, Apple Rehab Sport & Spa, Leslie Weissman will bill the insurance company listed on the Patient Information sheet.**

Signature:_____ Date:_____