Elmwood Orthopedic Rehab Center, Inc.

193 Elmwood Avenue
Providence, RI 02907
Tele: 401.459.4000 Fax: 401.459.4005

Health Insurance Intake Form

Intake Date: ____________________ Interviewer: ________________________

BASIC PATIENT INFORMATION

First Name: ___________________________ Last Name: _________________________ **M / F**

Address: ____

City: ______________________________ State: ______________ Zip: __________________

Home Phone: __________________________ Work Phone: ____________________________

Cell Phone/Pager: ________________________ Date of Birth: ___________________________

Social Security No: ______________________ License: _______________________________

Marital Status: **Single** **Married** **Divorce**

EMPLOYMENT INFORMATION

Employer Name: ____

Occupation: __________________________ Tele #: ______________________________

Are you missing time from work? **YES** **NO** (circle one)

How long? ____

HEALTH INSURANCE INFORMATON

Do you have Health Insurance? **YES** **NO** (circle one)

Name of Health Insurance Carrier: ____

Address: ____

Subscriber: ___________________________ Card No: ________________________________

Group No: ____________________________ Exp. Date: ______________________________

What are your major complaints: ____

____

Primary Care Physician: ____

____

Address: ____

Telephone No: ____

Referral obtained: YES NO

How many visits were approved: ____

____

DESCRIPTION OF INJURY/ COMPLAINTS

Brief description of injury/complaints please write below:

____

____

____

____

I understand and agree that Health and Accident Insurance policies are an arrangement between the insurance carrier and myself. I authorize payment from my Insurance Carrier directly to this office with the understanding that all monies will be credited to my account upon receipt.

Patient’s Name: ____ Date: ______________________

Patients Signature: _____________________________________