ATLANTIC REHABILITATION CENTER
PATIENT INFORMATION

Today's Date_____ Facility NMB **P D** Appt Date_____ Time_____

Last Name:_____ First:_____ Middle:_____

Address:_____ City:_____ State:_____ ZIP:_____

Home (___)_____-_____Work: (____)____-_____.ext_____. Cell/BP:(___)_____-_____

DOB:____/____/_____ Sex: M/F Marital Status: S M W D U SS#:_____-_____-_____

Email address:_____

Emergency Contact:_____ Phone: (___)_____-_____

Referring Doctor Information

Referring Dr._____ Phone:_(___)_____-_____ Fax:(___)_____-_____

Diagnosis:_____ Body part:_____ Surgery Date: ____/____/_____

NPI#_____ ICD9 _____ DOI____/____/_____

Employer Information

Employer Name:_____ Phone: (___)_____-_____ Occupation_____

Address:_____ City:_____ State:_____ Zip:_____

Accident/ Insurance Information

HMO POS PPO MEDICARE W/C SCHOOL SELF-PAY MEDICAID AUTO

Primary Insurance:_____ Phone:_(_____)_____-_____

Policy/ claim/ ID#:_____ Group#_____

Primary Insured_____ Relationship to PT_____

Secondary Insurance:_____ Phone:_(____)_____-_____

Primary Insurance Verification/ Explanation of Benefits

Policy effective date:____/____/____ Pre-cert Req: Y or N Contact Name:_____

Deductible:_____ Met:_____ Co-Pay:_____ Pt percentage_____

Max visits allowed:_____ Max $ allowed:_____ Benefits exhausted: Y or N

Claim address:_____

Completed by:_____ Date:____/____/_____