ABSOLUTE REHABILITATIVE THERAPY INC.
3200 Crain Highway Suite 103
Waldorf, MD 20603

PATIENT DEMOGRAPHICS

PATIENT'S NAME:_______________________________________

ADDRESS:____

CITY:____________________________ST________ ZIP_________

HOME TEL NUMBER:____________________________________

CELL PHONE: ____

EMAIL ADDRESS: _______________________________________

DATE OF BIRTH: _______/_________/_________

SOCIAL SECURITY NUMBER: ____________________

SEX: M = MALE F = FEMALE (CIRCLE ONE)

STATUS: SINGLE / MARRIED / DIVORCED / WIDOWED / CHILD / (CIRCLE ONE)

EMERGENCY CONTACT:

NAME: ____

RELATIONSHIP:___________ TEL #_________________________

ATTENDING/ REFERRING PHYSICIAN INFO:

MD'S NAME: ____

PHONE NUMBER: _______________________________________

PRIMARY MEDICAL INSURANCE:

INSURANCE: ____

SUBSCRIBER'S NAME:___________________________________

SUBSCRIBER'S DOB: __________________________________

EMPLOYER: ____

MEMBER ID #: ____

GROUP #: ____

MEDICAL RELEASE/AUTHORIZATION OF PAYMENT: I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I FURTHER AUTHORIZE PAYMENT TO BE MADE DIRECTLY TO ABSOLUTE FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO ABSOLUTE FOR ALL CHARGES NOT COVERED.

_________________________________ ________________

Patient Signature/Responsible Party **Date**

How did you hear about us? _______________________________

INJURY/ ONSET : (CIRCLE ONE)

IS INJURY RELATED TO AUTO? _____ YES ____ NO

IS INJURY RELATED TO WORK? _______YES ______NO

DATE OF INJURY/ ONSET: _____/_______/_________

CAUSE OF INJURY: __________________________________

INJURY BODY PART: ________________________________

DATE OF SURGERY: _________________________________

HAVE YOU HAD PRIOR PHYSICAL THERAPY? ___YES ___NO

WHEN? _________________ BODY PART:______________

EMPLOYER INFORMATION:

EMPLOYER:_____________________________________

WORK PHONE: __________________________________

JOB TITLE: ______________________________________

SECONDARY INSURANCE INFORMATION:

INSURANCE: ____

SUBSCRIBER'S NAME: _____________________________

SUBSCRIBER'S DOB: ____/____/____ SS#: _____________________

EMPLOYER: ____

MEMBER ID: ____

GROUP NUMBER: ____

WORKER'S COMPENSATION / AUTO-PIP INSURANCE: (CIRCLE ONE)

INSURANCE: ____

CLAIM #: ____

DATE OF ACCIDENT: _____________________________________

ADJUSTER'S NAME: ______________________________________

ADJUSTER'S PHONE: _____________________________________

ADDRESS TO SUBMIT THE CLAIM:_________________________

____

CITY: ___________________ ST: __________ ZIP: _____________

ATTORNEY INFORMATION:

ATTORNEY NAME:____

PHONE #____

FAX #____

ADDRESS:____

CITY:_______________________ST______ZIP_____________________