



Office Use Only
Patient # _____

Patient Personal Information

Patient Information

Patient Name		Home Phone		Cell Phone	
Address		City		State	Zip
Marital Status	Spouse Name	Your Date of Birth	Your Social Security #		
Email Address					

Primary Physician Information

Primary Care Physician		Phone		Fax	
Address		City		State	Zip

Emergency Contact Information

Name		Relationship			Home Phone
Address		City	State	Zip	Work Phone

Employment Information

Employer Name (Full or Part-time)		Work Phone			
Address		City		State	Zip

Is this Visit a Result of: Accident: ___ Work Comp: ___ Motor Vehicle Accident: ___ Other: _____

If W/C, Employer Name	Contact	Phone Number

Assignment of Benefits:

I directly assign all medical benefits, including major medical benefits and Medicare, to Pro Fit Rehab, LLC. 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, LLC 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: _____