



Northeast Rehab
791 South Hwy 78
Wylie, TX 75098

Registration

Patient Information

_____		_____	
(First, Middle, Last Name)		(Date of Birth)	
_____		_____	
(Address)		(City, State, Zip Code)	
_____	_____	_____	
(Home Telephone Number)	(Work Telephone Number)	(Social Security Number)	
_____		_____	
(Cell Phone)		(Driver's License Number)	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female			
Employment Status: <input type="checkbox"/> Employed <input type="checkbox"/> Part-time Student <input type="checkbox"/> Full-time Student <input type="checkbox"/> Other			

Employment Information

_____		_____
(Occupation)		(Employer)
_____		_____
(Address)		(City, State, Zip)

Spouse Information

_____		_____
(Name)		(Date of Birth)
_____	_____	
(Social Security Number)	(Occupation)	
_____		_____
(Employer)		(Employer Phone Number)

Responsible Person (If Applicable)

_____		_____	_____
(Name)		(Date of Birth)	(Relationship to Patient)
_____		_____	
(Address)		(City, State, Zip Code)	
_____	_____	_____	
(Phone Number)	(Social Security Number)	(Occupation)	
_____		_____	
(Employer)		(Employer Phone Number)	

Relative to Contact in Case of Emergency (Not Living in Home of Patient)

(Name)

(Phone Number)

(Relationship to Patient)

(Address)

(City, State, Zip Code)

Insurance Information

Please indicate how you will pay for your visits with our office:

- Health Insurance (please give your card to the receptionist)
- Workers Compensation (please fill out Workers Compensation information sheet)
- Automobile Insurance / Attorney (please fill out Auto Accident information sheet)
- Other: _____

How were you referred to our office?

- By an Attorney
- By a Doctor
- By a Patient
- Other

Please print the name of your source below.

Is your illness or injury related to any of the following?

- Employment
- Emergency
- Accident
- Auto Accident
- ____ None of the above

Briefly describe your symptoms:

DATE OF INJURY

Consent to Treatment

I voluntarily consent to receive medical and health care services that may include diagnostic procedures examinations and treatment.

Financial Responsibility and Assignment of Benefits

I agree to pay all charges for medical and health care services not covered by my insurance company.

I certify that I have read this form and understand its contents.

(Patient or Other Legally Authorized Person)

(Date)