DEMOGRAPHICS

Patient Name: ______________________________ Sex: ☐ Male ☐ Female
Last First Middle

Race: (Please Circle One) Asian, African American, American Indian, Caucasian, Hispanic, Other, Patient Declined

Date of Birth: ____________ Social Security #: ____________

Home Phone #: ____________ Cell Phone #: ____________

Street Address: ______________________________
Street or Route Apt # City State Zip

Marital Status: ☐ S ☐ M ☐ W ☐ D Spouse Name: ____________ Cell Phone #: ____________

Referred to: Dr. ____________ By: ____________

Who is your Primary Care Physician? ____________ Office Phone # ____________

Reason for Office Visit (Type of Injury/Problem/Illness): ____________

Diagnostic Testing in past 1 Month: Yes / No Where were the tests done? ____________

Is the Patient currently Employed? ☐ Yes ☐ No Financial Responsibility: ☐ Self ☐ Other

Patient's Employer: ____________ Address: ______________________________
Street City State Zip

Occupation: ____________ Work Phone #: ____________

INSURANCE INFORMATION

Primary Insurance: ____________ Insurance ID #: ____________
Subscriber Name: ____________ Subscriber DOB: ____________
Subscriber S.S. #: ____________ Relationship to Subscriber: ____________

Secondary Insurance: ____________ Insurance ID #: ____________
Subscriber Name: ____________ Subscriber DOB: ____________
Subscriber S.S. #: ____________ Relationship to Subscriber: ____________

Is this a Work Comp Injury/Claim? ☐ Yes ☐ No Insurance Name: ____________ Phone: ____________

IN CASE OF EMERGENCY

Name of local relative or friend (not living at same address): Relationship: ____________

NAME: ____________ Phone: ____________

Address: ______________________________
Street City State Zip

Authorization for Treatment and Financial Agreement: I do hereby consent to medical care encompassing such diagnostic procedures and medical treatment performed on me or ordered by my physician, his assistants, as is necessary in the judgment of my physician. I hereby authorize direct payment to physician of all medical insurance benefits (including without limitation Medicare and Medicaid benefits) to which the Patient is entitled in consideration of services to be rendered by Provider of services to the Patient. I understand that I am financially responsible for charges not covered by insurance benefit and guarantee payment for such charges. Release of Information: I hereby authorize the treating physician to release, to the extent permitted by law, any medical information acquired in the course of the Patient's examination and/or treatment to any insurance company assisting in payment of medical care provided. I also hereby authorize the release of any medical information to any licensed physician or facility to which Patient may be referred for further medical care.

Signature: ______________________________ Please Check One: ☐ Patient
☐ Parent or Guardian of Minor
Date: ______________________________ ☐ Authorized Representative

Above information verified each office visit:
Dates Verified: ______ ______ ______ ______ ______ ______ ______ ______ ______ ______ ______

St. Louis Medical Rehab Group, LLC
1025 Dunn Rd, Florissant, MO 63031 | (314) 736-1333