

**PATIENT REGISTRATION**

PATIENTS NAME \_\_\_\_\_ DATE \_\_\_\_\_

(Parents Name)-if student \_\_\_\_\_

ADDRESS (Parents address if student) \_\_\_\_\_

CITY \_\_\_\_\_ ZIP CODE \_\_\_\_\_ PHONE # \_\_\_\_\_

CELL# \_\_\_\_\_ PARENTS#(if student) \_\_\_\_\_

DOB \_\_\_\_\_ SS# \_\_\_\_\_ DRIVERS LICENSE# \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK# \_\_\_\_\_

SPOUSE NAME \_\_\_\_\_ EMPLOYER \_\_\_\_\_

DATE OF INJURY(if known) \_\_\_\_\_ AUTO/WORK COMP \_\_\_\_\_

REFERRED BY DR. \_\_\_\_\_ PHONE# \_\_\_\_\_

DR. ADDRESS \_\_\_\_\_

(Office Use): ICD# \_\_\_\_\_

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INSURED'S NAME \_\_\_\_\_ INSURED'S DOB \_\_\_\_\_

PRIMARY INSURANCE \_\_\_\_\_

ADDRESS \_\_\_\_\_

CLAIM# OR ID# \_\_\_\_\_ PHONE # \_\_\_\_\_

ADJUSTOR NAME \_\_\_\_\_ PHONE# \_\_\_\_\_

REPRESENTATIVE SPOKE TO \_\_\_\_\_ DATE \_\_\_\_\_

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SECONDARY INSURANCE \_\_\_\_\_

ADDRESS \_\_\_\_\_

CLAIM# OR ID \_\_\_\_\_ PHONE# \_\_\_\_\_

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**ASSIGNMENT OF INSURANCE BENEFITS/AUTHORIZATION TO RELEASE INFORMATION**

I HERBY INSTRUCT MY INSURANCE COMPANY, OR ATTORNEY TO PAY DIRECTLY TO COAST REHAB SERVICES, INC. ANY BENEFITS ALLOWABLE FOR THEIR PROFESSIONAL SERVICES RENDERED TO ME AT THEIR FACILITY. ANY SUM OF MONEY PAID UNDER THE ASSIGNMENT SHALL BE CREDITED TO MY ACCOUNT. I ALSO ASSUME ALL RESPONSIBILITY FOR ANY BALANCE ON MY ACCOUNT, AND AGREE TO PAY ANY ADDITIONAL CHARGE EQUAL TO THE COST OF COLLECTION INCLUDING AGENCY AND ATTORNEY FEES AND COURT COSTS INCURRED & PERMITTED BY LAWS GOVERNING THESE TRANSACTIONS. INTEREST ON UNPAID BALANCE WILL BE CHARGES AT 18% PER MONTH ON ACCOUNTS PAST 60 DAYS. I ALSO AUTHORIZE COAST REHAB SERVICES TO GIVE MY INSURANCE COMPANY ANY & ALL INFORMATION THEY MAY REQUIRE CONCERNING MY CASE.

PATIENT SIGNATURE \_\_\_\_\_