

WELCOME TO NORTHERN ROCKIES REHABILITATION & ATHLETIC TRAINING CENTER

Date: _____

PATIENT INFORMATION

Last Name _____ First _____ Middle _____
Address _____ City _____ ST _____ Zip _____
Home Phone # (____) _____ Work # (____) _____, Ext. _____ Age _____
Date of Birth ____/____/____ Social Security # _____ Driver's License # _____ State _____
Marital Status: Married _____ Single _____ Widow(er) _____ Divorced _____ Separated _____
Full Time Student: Yes _____ No _____ School Name: _____
Employer _____ Employer's Phone # _____
Employer's Address _____ City _____ ST _____ Zip _____
Name of Spouse (If applicable) _____ Date of Birth ____/____/____
Spouse's Employer _____ Employers Phone# _____
Employer's Address: _____ City _____ ST _____ Zip _____
Nearest Relative/Friend (Not Living With You) _____ Phone # _____

GUARANTOR INFORMATION: (If Different From Patient's Information)

Last Name _____ First _____ Middle _____
Address _____ City _____ ST _____ Zip _____
Home Phone # (____) _____ Work # (____) _____, Ext. _____ Age _____
Date of Birth ____/____/____ Social Security # _____ Driver's License # _____ State _____
Marital Status: Married _____ Single _____ Widow(er) _____ Divorced _____ Separated _____
Full Time Student: Yes _____ No _____ School Name: _____
Employer _____ Employer's Phone # _____
Employer's Address _____ City _____ ST _____ Zip _____

INSURANCE INFORMATION:

Type of Insurance: Commercial Insurance _____ Medicare _____ Medicaid _____ Champus _____ Private Pay _____ Other _____
Worker's Comp _____ Date of Injury ____/____/____
Primary Insurance Company Name: _____ Phone #(____) _____
Policy Holder's Name _____ Date of Birth _____
Policy # _____ Group# _____
Patient's Relationship to the Policy Holder? Self _____ Spouse _____ Child _____
Secondary Insurance Company Name: _____ Phone #(____) _____
Policy Holder's Name _____ Date of Birth _____
Policy # _____ Group# _____
Patient's Relationship to the Policy Holder? Self _____ Spouse _____ Child _____

Whom May We Thank For Your Referral? _____
Name of Primary Care Physician: _____ Phone #(____) _____

AUTHORIZATIONS:

TO PROMOTE A SAFE ENVIRONMENT FOR ALL INVOLVED, CHILDREN ARE NOT PERMITTED IN THE TREATMENT AREA UNLESS THEY ARE BEING TREATED. PLEASE MAKE OTHER CHILD CARE ARRANGEMENTS PRIOR TO TREATMENT.

I understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and plans for future care and treatment. The health records will be retained by Northern Rockies Rehabilitation & Athletic Training Center even if my healthcare provider(s) leave the practice.

Northern Rockies Rehabilitation & ATC has a cancel/ no-show policy that states you must notify our office 24 hours in advance if you are unable to keep your scheduled appointment. If you fail to keep your appointment, or do not notify us in advance, you will be charged \$25.00. A series of 3 missed appointment, or no-shows, will result in the cancellation of further appointments. You must then call our office to reschedule.

Signature of Patient / Legal Guardian: _____ Date: _____ Update: _____

As the party responsible for medical decision making for the child represented in this medical record, I hereby give my consent to Northern Rockies Rehabilitation & Athletic Training Center to render both emergency and non-emergency healthcare services both in and out of my physical presence.

Signature of Legal Guardian: _____ Date: _____ Update: _____