

Allied Health Rehab Centers

Akron
 388 S. Main Street
 44311
 (330) 543-2110
 (330) 543-3851 Fax

Barberton
 133 Fifth St., Ste B
 44203
 (330) 753-5113
 (330) 753-8530 Fax

Cuyahoga Falls
 650 Graham Road
 Suite 107
 44221
 (330) 920-1002
 (330) 920-0923 Fax

Mogadore
 35 N. Cleveland Ave.
 Suite C
 44260
 (330) 628-0736
 (330) 628-0739 Fax

Wadsworth
 323 High Street
 Suite 102
 44281
 (330) 335-0026
 (330) 335-2389 Fax

Appt. Date: _____

Therapist: _____

Acct.#: _____

Patient Name:		Social Security #:	
Address:		_____ Male	_____ Female
City:	State:	Zip:	
Phone:	Date of Birth:	<u>Circle</u> : Single Married Divorced Widow Other	
Patient Employer/School Name:		Phone:	
Address:	City:	State:	Zip:

Responsible Person:		Relationship to Patient:	
Resp. Person Address:		City:	State: Zip:
Emergency Contact:	Phone:	Patient's E-Mail:	
No Billing, Informational Only			

Referring Physician:	Primary Care:
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Is Patient's Condition Related to: Auto___ Employment___	Date on Onset/ Injury Date: ___/___/___
Has patient had chiropractic, physical, occupational or speech therapy this year? Yes___ No___ How Many?? _____	
If Yes, Date(s) Seen _____ Where seen ? _____	
MEDICARE PATIENTS: Have you had any In-Home / Home Health Care this year ?	Yes___ No___
If Yes, Date(s) Seen _____	By Whom / What Agency ? _____
How did you become aware of our services? Physician___ Patient___ Ad___ Radio___ Website___ School___ Other___	

Primary Insurance: Health___ Auto___ Workers' Comp___ Other___

Name of Insurance:	Phone#:
Policy Holder:	SS#: Date of Birth:
Policy / ID#:	Group #: Employer:

Secondary Insurance: Health___ Auto___ Workers' Comp___ Other___

Name of Insurance:	Phone#:
Policy Holder:	SS#: Date of Birth:
Policy / ID#:	Group #: Employer: