

Allied Health Rehab Centers

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

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: