

SOUTHWEST ADVANCED NEUROLOGICAL REHABILITATION, LLC
PATIENT DEMOGRAPHIC INFORMATION

Today's Date: _____

Patient Information

Patient Name _____
Last First Middle Initial

Gender: M _____ F _____ Date of Birth ____/____/____ Age _____

Social Security Number _____ - _____ - _____ Marital Status: S M W D Sep

Local Address _____

City _____ State _____ Zip Code _____ Local Phone (____) _____

Permanent Address _____

City _____ State _____ Zip Code _____ Permanent Phone (____) _____

Cell Phone _____ Email _____

Date of Stroke/Injury ____/____/____ Name of Spouse/Parent/Guardian (circle one) _____

How did you hear of us or who referred you? _____

EMERGENCY CONTACT: _____ Relationship _____

Phone(s) (____) _____ Cell Phone (____) _____

Physician Information

Referring Physician _____ Phone (____) _____

Fax (____) _____

Office Location: Street Address _____

City _____ State _____ Zip _____

Patient's Primary Physician _____ Phone (____) _____

Office Location: Street Address _____

City _____ State _____ Zip _____

Responsible Party Information

Name: _____

Employer: _____ Occupation _____

Street Address _____

City _____ State _____ Zip _____

Insurance Information

Primary Insurance Company: _____

Street _____ City _____ State _____ Zip Code _____

ID# _____ Policy # _____ Group # _____

Policy Holder's Name _____ Relationship to Patient _____

SS # _____ - _____ - _____ Date of birth _____

Policy Holder's Address (if other than patient's):

Street _____ City _____ State _____ Zip Code _____

Policy Holder's Employer:

Street _____ City _____ State _____ Zip Code _____

Secondary Insurance Company: _____

Street _____ City _____ State _____ Zip Code _____

ID# _____ Policy # _____ Group # _____

Policy Holder's Name _____ Relationship to Patient _____

SS # _____ - _____ - _____ Date of birth _____

Policy Holder's Address (if other than patient's):

Street _____ City _____ State _____ Zip Code _____

Policy Holder's Employer:

Street _____ City _____ State _____ Zip Code _____

Assignment of benefits/authorization to release information

I authorize payment of my insurance benefits directly to SWAN Rehab. I understand I am personally responsible for balances not paid by my insurance.

x _____ Date /_____/_____
Patient/Responsible Party

I authorize SWAN Rehab to release any medical records necessary to assist with the processing of my claim.

x _____ Date /_____/_____
Patient/Responsible Party