

<p><b>Name:(first)</b> _____</p> <p style="padding-left: 40px;"><b>(last)</b> _____</p> <p><b>Address:</b> _____</p> <p style="padding-left: 40px;">_____</p> <p><b>Social Security #:</b> _____</p> <p><b>Referring/family Physician:</b> _____</p> <p><b>Employer:</b> _____</p> <p><b>Employer address:</b> _____</p> <p><b>Employer phone:</b> _____</p> <p><b>Occupation:</b> _____</p> <p style="text-align: center;"><b>Gender:</b> Male ___ Female ___</p> <p><b>Birth date:</b> _____ <b>Age:</b> _____</p> <p><b>Phone:(Home)</b> _____</p> <p style="padding-left: 40px;"><b>(Work)</b> _____</p> <p style="padding-left: 40px;"><b>(Cell)</b> _____</p> <p><b>Emergency contact:</b></p> <p style="padding-left: 40px;"><b>Name:</b> _____</p> <p style="padding-left: 40px;"><b>Phone:</b> _____</p>	<p><b>Marital Status:</b> Single ___ Married ___ Divorced ___ Widowed ___</p> <p><b>Spouse/Guardian's Name:</b> _____</p> <p><b>Spouse/Guardian's Address:</b> _____</p> <p><b>Spouse/Guardian's Employer:</b> _____</p> <p><b>Spouse/Guardian's Birth date:</b> _____</p> <p>*****</p> <p><b>Primary Insurance:</b> <i>Please provide copy of card</i> (Name of Insurance:)</p> <p><input type="checkbox"/> <b>Medicare</b> _____</p> <p><input type="checkbox"/> <b>Group Health:</b> _____</p> <p><input type="checkbox"/> <b>Worker's comp:</b> _____</p> <p style="padding-left: 40px;"><b>DOI:</b> _____ <b>Claim#:</b> _____</p> <p style="padding-left: 40px;"><b>Employer:</b> _____</p> <p><input type="checkbox"/> <b>Auto:</b> _____</p> <p style="padding-left: 40px;"><b>DOI:</b> _____</p> <p style="padding-left: 40px;"><b>Claim#:</b> _____</p> <p style="padding-left: 40px;"><b>State of accident:</b> _____</p> <p><input type="checkbox"/> <b>Other:</b> _____</p> <p><b>Policyholders Name:</b> _____</p> <p><b>Address:</b> _____</p> <p><b>Phone:</b> _____</p> <p><b>Birth date:</b> _____ <b>Gender: Male ___ Female ___</b></p> <p><b>Relationship to Patient:</b> _____</p>
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I hereby authorize Penn-Ohio Rehabilitation to provide medical treatment to myself /my dependent.  
I hereby authorize Penn-Ohio Rehabilitation to release to my insurance carrier and its agents any information needed to determine benefits and process claims for services provided to me by Penn-Ohio Rehabilitation and/or required by law. I request that payment of benefits, including any government benefits (Medicare/Medigap), to Richard L. Holzworth dba Penn-Ohio Rehabilitation for services furnished to me by that provider. I understand and agree that I will be responsible for any portion of payment as determined by my insurance policy. I certify that I have provided true and accurate information to the best of my knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_