Penn Ohio Rehabilitation
PHYSICAL • OCCUPATIONAL • AQUATIC

1599 North Hermitage Road, Hermitage, PA 16148
724-962-7920
152 Waugh Avenue, New Wilmington, PA 16142
724-946-3313
www.pennohiorehab.com

Name: (first)_____

(last)_____

Address: (street)_____

(city/state)_____

Social Security #:_____

Employer:_____
(School/College, if a student)

Employer Address: (street)_____

(city/state)_____

Occupation:_____
(If school/college listed, designate if full or part-time student)

Gender: Male_____ Female_____

Birthdate:_____

Age:_____

Phone: (home)_____
(work)_____
(cell) _____

E-mail:_____

***EMERGENCY CONTACT:*
*Name:*_____

*Phone:*_____ *Relationship:*_____

*Family Physician:*_____
*Ambulance Service:*_____

Marital Status:
Single__ Married__ Divorced__ Widowed__

Spouse Name:_____
(Guardian, if patient is a child or dependent)
Address: (street)_____

(city/state)_____

Birthdate:_____

Employer:_____

Primary Insurance: *Where should bill be sent?*

☐ **Medicare/HMO:** *Please provide copy of card*

☐ **Group Health:** *Please provide copy of card*
Policy holder information(if other than patient):
Name: _____
Address:_____
Birthdate:_____
Relationship to patient:_____

☐ **Workers Comp:**
Employer:_____
Emp Address:_____
Phone:_____
Insurance Carrier:_____
Date of Injury: _____
Claim #:_____

☐ **Auto:**
Insurance Company:_____
Address:_____
Phone:_____
Date of Accident:_____
Claim #: _____

☐ **Other:**_____

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*******How did you hear about us?*********
Radio_____ TV_____ Newspaper _____
Other:_____

I hereby authorize Penn-Ohio Rehabilitation, PC to provide medical treatment myself/my dependent.
I hereby authorize Penn-Ohio Rehabilitation, PC 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, PC and /or required by law. I request that payment of benefits, including any government benefits (Medicare/Medigap), be sent to Penn-Ohio Rehabilitation, PC 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:**_____