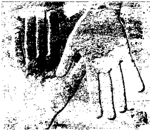
TRAHC



Tuscaloosa
Rehabilitation
And
Hand
Center

APPOINTMENT DATE: ___________________
APPOINTMENT TIME: ___________________
COMPLETED BY: _______________________

ACCOUNT # ___________________

PATIENT DATA AND INSURANCE INFORMATION SHEET

General Insurance

PATIENT INFORMATION

Patient Name: _____________________________ Social Security#: ______________________________
Home Phone: _____________________ Cell Phone:___________________ Work Phone: __________________
Address: ____________________________________ City: ________________________ State: _________
Zip: __________________ Birth date: _______________ Sex: M F Marital Status: M S D W
Employer: ______________________________ Employer Address: _________________________________
City: ________________________________ State: ____________ Zip: _______________
Emergency Contact: ____________________________________ Contact Phone: _______________________

MEDICAL INFORMATION

Referring MD: ______________________________ UPIN #: _____________ Services Ordered: PT / OT
Surgery? Y N Date of Surgery: _________________ Type of Accident: None / Work Comp / Auto / Other
Accident/ Injury/ Onset Date: _________________ Details: _____________________________________
Prescription Date: __________________ # of visits ordered: __________ # of visits approved: __________
Return visit to MD:______________________________________

INSURED PARTY INFORMATION – Same? Yes No

(if no, please complete the following section)

Insured Party Name: ___________________________ Social Security#: ______________________________
Home Phone: _____________________________ Work Phone: __________________________________
Address: ____________________________________ City: ________________________ State: _________
Zip: __________________ **Birth date**: _______________ Employer: ________________________________
Employer Address: ________________________________ City: _______________________ State: _______
Zip: ____________________ Patient Relationship to Insured: Self / Spouse / Parent / Child / Other

PRIMARY INSURANCE

PRIMARY INSURANCE: ______________________ Phone: __________________ Fax: ___________________
Policy / Claim # ______________________________ Group # ________________ Group Name: ___________
Insured Name: _____________________________ Ins. Rep: _____________ Effective Date: ___________
Deductible: _______________ Amount Met: _________________ Out of Pocket: ______________________
Copay / Patient Portion Amount: ______________ Precert Required? ________ Expiration Date: _________

SECONDARY INSURANCE

SECONDARY INSURANCE: ______________________ Phone: __________________ Fax: _________________
Policy / Claim # ______________________________ Group # ________________ Group Name: ___________
Insured Name: _____________________________ Ins. Rep: _____________ Effective Date: ___________
Billing Address: ______________________________ City: _________________ State: ___________________
Zip: _____________________________ Comments: ____