# California Rehab Sports Therapy

P O Box 511321
Los Angeles, CA 90051-7876
(800) 929-4776

## PATIENT INFORMATION

| NAME (Last, First Middle) | MRN | SSN# | BIRTHDATF | LANGUAGE | SEX |
|---|---|---|---|---|---|
| | | | | | |

| LOCAL ADDRESS | SECONDARY/BILLING ADDRESS (if Applicable) | ETHNICITY |
|---|---|---|
| | | |

| CITY, STATE ZIP | HOME PHONE | CITY, STATE ZIP | HOME PHONE | RACE |
|---|---|---|---|---|
| | | | | |

| PRIMARY CARE PHYSICIAN | REFERRING PHYSICIAN | CONTACT NAME | CONTACT HOME PHONE |
|---|---|---|---|
| | | | |

| PRIMARY EMPLOYER | SECONDARY EMPLOYER (if Applicable) |
|---|---|
| ADDRESS | ADDRESS |
| CITY, STATE ZIP | CITY, STATE ZIP |
| WORK PHONE | WORK PHONE |

## RESPONSIBLE PARTY INFORMATION (Required, if no guarantor found and patient is less than 18.)

| NAME (Last, First Middle) | SSN# | BIRTHDATE | LANGUAGE | SEX |
|---|---|---|---|---|
| | | | | |

| LOCAL ADDRESS | SECONDARY/BILLING ADDRESS (if Applicable) |
|---|---|
| CITY, STATE ZIP | CITY, STATE ZIP |
| HOME PHONE | HOME PHONE |
| RELATIONSHIP TO PATIENT | |

## PRIMARY INSURANCE

| NAME OF INSURANCE COMPANY | POLICY# | |
|---|---|---|
| NAME OF INSURED | GROUP# | |
| ADDRESS OF INSURANCE COMPANY | COPAY AMT | |
| CITY, STATE ZIP | DEDUCTIBLE | |
| RELATIONSHIP TO PATIENT | EFFECTIVE DATE | EXPIRATION DATE |

## SECONDARY INSURANCE (if Applicable)

| NAME OF INSURANCE COMPANY | | | POLICY# | |
|---|---|---|---|---|
| NAME OF INSURED | SSN# | BIRTHDATE | GROUP# | |
| ADDRESS OF INSURANCE COMPANY | | | COPAY AMT | |
| CITY, STATE ZIP | | | DEDUCTIBLE | |
| RELATIONSHIP TO PATIENT | | | EFFECTIVE DATE | EXPIRATION DATE |

SIGNATURE OF PATIENT/GUARDIAN ____________________ DATE ____________________