

Chicago Area Rehabilitation Experts, Inc.

NEW PATIENT REGISTRATION

ASSIGNED TO: _____

APPT. DATE / /

PLEASE PRINT

PATIENT INFORMATION					
LAST NAME	FIRST	MI	DATE OF BIRTH / /	SOCIAL SECURITY NUMBER	SEX
HOME ADDRESS		CITY	STATE	ZIP CODE	HOME PHONE ()
MARITAL STATUS SINGLE () MARRIED () OTHER ()		HOW WERE YOU REFERRED?			
EMPLOYMENT STATUS EMPLOYED () FULL TIME STUDENT () PART TIME STUDENT () N/A ()			EMPLOYER NAME / SCHOOL NAME		TITLE / POSITION
WORK ADDRESS		CITY	STATE	ZIP CODE	WORK PHONE ()
EMAIL ADDRESS		CELL PHONE			

REFERRING PHYSICIAN INFORMATION-Who wrote the perscription?				
LAST NAME	FIRST	MI	ADDRESS	TELEPHONE ()

PRIMARY CARE PHYSICIAN INFORMATION-Your family Doctor				
LAST NAME	FIRST	MI	ADDRESS	TELEPHONE ()

REASON FOR TODAY'S VISIT			
IS THIS INJURY / CONDITION RELATED TO YOUR ...			
JOB: YES () NO ()	CAR: YES () NO ()	HOME: YES () NO ()	OTHER ACCIDENT: YES () NO ()
PLEASE INDICATE THE DATE OF ACCIDENT OR INJURY: / /		PLEASE INDICATE THE DATE OF ILLNESS (1ST SYMPTOM) / /	
PLEASE PROVIDE NAME OF INSURANCE ADJUSTER OR CONTACT:			TELEPHONE:
PLEASE DESCRIBE INJURY / ACCIDENT / ILLNESS:			

RESPONSIBLE PARTY STATEMENT		
AS THE RESPONSIBLE PARTY, I AGREE THAT ALL CHARGES THAT ARE NOT DIRECTLY PAID BY MY INSURANCE COMPANY WILL BE MY RESPONSIBILITY.		
RESPONSIBLE PARTY SIGNATURE X	TODAY'S DATE / /	

PRIMARY INSURANCE COMPANY INFORMATION

PRIMARY INSURANCE COMPANY NAME		IDENTIFICATION NUMBER		GROUP NUMBER
ADDRESS		STATE	ZIP CODE	PHONE
POLICYHOLDER (if other than patient)		SEX	DATE OF BIRTH	
SOCIAL SECURITY NUMBER (of policyholder)	PHONE NUMBER (of policyholder)		RELATIONSHIP TO PATIENT	

ASSIGNMENT OF BENEFITS / AUTHORIZATION TO RELEASE MEDICAL INFORMATION / CONSENT TO TREATMENT

I HEREBY ASSIGN ALL MEDICAL BENEFITS TO WHICH I AM ENTITLED TO CHICAGO AREA REHABILITATION EXPERTS, INC., IN THE EVENT THEY FILE INSURANCE ON MY BEHALF. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. **ANY BALANCE UNPAID AFTER 120 DAYS IS SUBJECT TO A MONTHLY FINANCE CHARGE OF 18%.** VERIFICATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT OR A GUARANTEE OF PAYMENT ACCORDING TO THE ACTUAL BENEFITS QUOTED. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF SAID BENEFITS. A COPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. I DO HEREBY CONSENT TO SUCH TREATMENT BY THE AUTHORIZED PERSONNEL OF CHICAGO AREA REHABILITATION EXPERTS, INC. AS MAY BE DICTATED BY PRUDENT MEDICAL PRACTICE BY MY ILLNESS, INJURY OR CONDITION. THIS CONSENT IS INTENDED AS A WAIVER OF LIABILITY FOR SUCH TREATMENT EXCEPTING ACTS OF NEGLIGENCE.

AUTHORIZED SIGNATURE: X	TODAY'S DATE: / /
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