Performance Work Rehabilitation
Patient Registration

TODAY'S DATE: _____

CLIENT/PATIENT INFORMATION	
MR MRS MS MISS (Please Circle)	HOME PHONE
LAST FIRST MI	WORK PHONE
ADDRESS	CELL PHONE
CITY STATE ZIP	EMPLOYER
SOCIAL SECURITY #	EMPLOYMENT/STUDENT STATUS (Please Circle) Employed Student Full Time Part Time
BIRTHDATE SEX: M F	PRIMARY PHYSICIAN
MARITAL STATUS (Please Circle) SINGLE MARRIED OTHER	REFERRING PHYSICIAN

INFORMATION ON PERSON RESPONSIBLE FOR CHARGES NOT PAID BY INSURANCE (GUARANTOR)	
MR MRS MS MISS (Please Circle)	GUARANTOR HOME PHONE
LAST FIRST MI	GUARANTOR WORK PHONE
SOCIAL SECURITY #	EMPLOYER
ADDRESS	EMPLOYER ADDRESS
CITY STATE ZIP	EMPLOYER PHONE
RELATION TO CLIENT/PATIENT	

IS THE CLIENT/PATIENT COVERED BY MEDICAL INSURANCE? YES NO			
INSURANCE INFORMATION	PRIMARY	SECONDARY	OTHER
INSURANCE NAME			
SUBSCRIBER'S NAME			
SUBSCRIBER'S EMPLOYER			
SUBSCRIBER'S ID# OR SOCIAL SECURITY NUMBER			
GROUP, MEMBER#, OR CLAIM#			
SUBSCRIBER'S BIRTHDATE			
SUBSCRIBERS SEX M F			
SUBSCRIBER'S ADDRESS IF DIFFERENT FROM CLIENT			
SUBSCRIBER'S PHONE IF DIFFERENT FROM CLIENT			
RELATION OF CLIENT/PATIENT TO SUBSCRIBER			
SUBSCRIBER'S WORK PHONE			

Complete other side →

Performance Work Rehabilitation
Client Registration Continued

IS THIS INJURY JOB-RELATED? YES _____ NO _____ DATE OF INJURY _____

BRIEFLY DESCRIBE INJURY: _____

_____

_____

WHERE DID THE INJURY OCCUR? _____

_____

_____

EMERGENCY CONTACT: _____ PHONE: _____

RELATION TO THE CLIENT: _____

Consent for Treatment & Payment

I, the undersigned, hereby request evaluation and treatment by Performance Work Rehabilitation and consent to care and treatment as ordered by my physician(s). I authorize the release of information related to my rehabilitation to my physician(s).

I hereby authorize my health insurance company to make payment directly to Performance Work Rehabilitation, Inc. for any benefits I may receive. I realize that this may not represent the full payment for services rendered and that I will be responsible for the balance due within 90 days (except for L & I/Workman's Compensation clients whose claim is currently open). I authorize the release of any information necessary to process my insurance claims and facilitate payment of my account by a third party.

(A rebilling fee of 1% or $5.00 will be charged to accounts 60 days past due if monthly payments are not received.)

_____ _____

Signature of patient/client or guardian (if a minor) Date