

Virginia Health Rehab Patient Information Form

Please Print Clearly

Patient's Last Name: _____ Discipline: PT ___ OT ___ ST ___
First Name, MI: _____ Sex: M ___ F ___
Phone Number: _____ Alternate Number: _____
D.O.B.: ____/____/____ Social Security # _____
Address: _____
City, State, Zip: _____
Guardian/Parent (if patient is a minor): _____
Guardian/Parent Social Security # _____ D.O.B.: ____/____/____
Onset Date/Date of Injury: _____ Marital Status: M ___ S ___ W ___ D ___
Referring Physician: _____ UPIN: _____
Is there an attorney involved? ___ No ___ Yes If so, who? _____

Primary Insurance Information: Type of insurance: _____
Address: _____
Subscriber: _____ ID# _____
Relation to Insured: ___ Self ___ Spouse ___ Child ___ Other
Prior Authorization #: _____ Group # _____
Plan # _____ Referral from PCP No ___ Yes ___ Who? _____

Secondary Insurance Information: Type of insurance: _____
Address: _____
Subscriber: _____ ID# _____
Relation to Insured: ___ Self ___ Spouse ___ Child ___ Other
Prior Authorization #: _____ Group # _____
Plan # _____ Referral from PCP No ___ Yes ___ Who? _____

Worker's Comp – Employer Name: _____ Employer Phone: _____
Address: _____
Workers Comp Carrier: _____ Auth. #: _____
Case Manager: _____ Phone/Fax: _____
Adjustor: _____ Phone/Fax: _____