Kessler Institute for Rehabilitation

REGISTRATION FORM

(Please Print)

Today's Date _____/_____/_____ Appt Date:____/_____/_____ PCP____________________________ Tel:_______________________

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

First time here at Kessler? ❑ Yes ❑ No	If no, which year were you here?		Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	City	State	ZIP Code	Social Security	Home Phone No. ( )

P.O. Box	City	State	ZIP Code

Occupation	Employer	Employer Phone No. ( )

Referred to Clinic by ❑ Dr. _________________________ Tel:_______________________

❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other ____________________

Comments:

INSURANCE INFORMATION

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No.(if different)
Is this person a patient here?	❑ Yes ❑ No		( )

Occupation	Employer	Employer Address	Employer Phone No. ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ Aetna ❑ Cigna ❑ Oxford ❑ BC/BS ❑ BC/BS HMO

❑ Medicare ❑ Medicaid ❑ Self-Pay ❑ Welfare ❑ Other ____________________

Telephone#____________________________

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other ____________________

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other Telephone#____________________

IN CASE OF EMERGENCY

Name of Friend or Relative	Relationship to Patient	Home Phone No.	Work Phone No.
		( )	( )

REASON FOR VISIT

DIAGNOSIS		**ICD9 CODE**:
	REGISTRAR SIGNATURE	DATE