GRAYSLAKE REHABILITATION
AND COMPLETE PHYSICAL THERAPY, LLC

PATIENT INFORMATION

Patient Name:_____ **Birthdate** _____/_____/_____
Last First MI

Address: _____

City/State/Zip:_____

Home Phone: (____)_____ **Cell Phone**: (____)_____

Patient SSN: _____ **Sex**: M or F **Marital Status**: S M D O

E-mail address: _____

Physician: _____ **Date of Injury/Accident**: _____/_____/_____

Patient or Parent's Employer: _____

Employer Address: _____

Work Phone: (____)_____

Emergency Contact: _____ **Phone #**: (____)_____

Relationship:_____ If a minor, parent's names: _____

INSURED INFORMATION

Insurance Company: _____ PPO POS HMO W/C Auto

Insured Name: _____ **Birthdate**:_____/_____/_____
Last First MI

Address (If different than above): _____

City/State/Zip:_____ **Insured SSN**: _____

I consent to Physical Therapy for myself or my child by Grayslake Rehabilitation and Complete Physical Therapy, LLC. I hereby authorize release of any information concerning myself or my child's healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. Payment of insurance benefits otherwise payable to me may be paid to Grayslake Rehabilitation. I understand that I am responsible for any amounts the insurance does not pay.

_____ _____
Signature of patient/ or parent/guardian **Date**