Rehabilitation Associates of Naples
Comprehensive Rehabilitation Services...to help meet life's challenges

Patient Information Form

PATIENT's NAME: ____ Date: _______________
(First) (Middle) (Last)

Date of Birth: _______________________ Social Security Number: ___________________
Address: ____
City/State/Zip: ____
Home Phone: _________________________ Cell Phone: ________________________
E-Mail Address:____

SPOUSE's NAME: _________________________________ Date of Birth: _______________
Dependent(s): ____

EMPLOYER: ______________________________________ WORK PHONE: _____________

Out of Area Address: ____
City/State/Zip: ____

Ethnicity: Hispanic / Non-Hispanic Race: __________ Preferred Language: ___________
(i.e., American, French, etc)

EMERGENCY CONTACT: __________________________ Phone: _______________________

MEDICAL INSURANCE INFORMATION

Primary Insurance Company: ____

Insurance Company Address: ____
Name of Employer if GROUP POLICY: ____
Name of Insured: ______________ Relationship to Patient: __________________
Insured SS#: _______________ Insured DOB: __________________

Secondary Insurance Company: ____
Name of Employer if GROUP POLICY: ____
Name of Insured: ______________ Relationship to Patient: __________________
Insured SS#: _______________ Insured DOB: __________________

Pharmacy Information: ___________________________ Phone: _______________________
Address (Street/City): ___________________________

Are you Currently Enrolled in Home Health: Yes ____ No _____ Agency: ____________________

A copy of your insurance card(s) is necessary. Please present them to the Receptionist.
Any Co-Pay amounts are to be paid at the time of service.