Arm and Hand Rehab
6692 Merchandise Way, Suite C
Diamond Springs, CA 95619
Ph: 530-621-1149 Fax: 530-626-3049
www.armandhandrehab.com

Patient Intake Sheet

Patient Name (first)_______________________(MI)____(last)______________________________________

Address:____ Date of Injury________________________

City:____ State:______ Zip Code:__________________

Date of Birth:_________________________________ SS#:_____________________________ Gender F M

Phone: Home:________________________ Mobile:______________________ Work:_____________________

Email Address:_________________________ Emergency Contact___________________ Phone____________

Relationship:_______________________ Legal Guardian____

We will be billing your insurance? (please circle all that apply)

Primary Insurance: (Please provide a copy of both sides of your insurance card)

Company____ Plan name_____________________________

Policy #____ Phone #_______________________________

Address____ City/State__________________ Zip__________

Name of Subscriber_____________________________________ Relationship to Subscriber______________

Subscriber SSN#____ Subscriber Date of Birth________________

Secondary Insurance: (Please provide a copy of both sides of your insurance card)

Company_______________________________________ Plan Name_____________________________________

Policy#____ Phone #____

Address_______________________________________ City/State________________________ Zip___________

Name of Subscriber_____________________________________ Relationship to Subscriber_______________

Subscriber SSN#____ Subscriber Date of Birth_________________

Workers Compensation Insurance Information:

Name of Employer____ Claim#_________________________

Name of Adjustor/Contact_________________________________ Phone______________________________

Name of Insurance Carrier_________________________________ Phone______________________________

Address_______________________________________ City/State________________________ Zip___________

Attorney___________________________________ Phone____________________ Fax_____________________

I hereby authorize payment of insurance benefits directly to Arm and Hand Rehab. I understand that this clinic files insurance claims as a courtesy service to the patients. I also understand that I am responsible for all costs of treatment should my insurance company deny payment.

Signature____ **Date**_______________________