373 Blair Park Road, Suite 204, Williston, VT 05495
(P) 802-662-4672 (F) 802-662-5964
www.kidsrehabgym.org

New Patient Information Sheet

Patient Name _____

Patient date of birth:_____ SS#: _____

Parent name: _____ Email _____

Telephone number :_____ Alternative_____

Address: _____

Emergency contact (name)_____ (Number)_____

Primary Insurance:

Insurance company: _____ ID number: _____

Name of policy holder (or self): _____ Relationship to patient: _____

If not self:

DOB of policy holder _____

SS number of policy holder: _____

Employer of policy holder: _____

Address of policy holder (if different from patient): _____

_____

Secondary insurance:

❑ I do not have a secondary insurance (leave this section blank)

Insurance company: _____ ID number: _____

Name of policy holder (or self): _____

Physician information:

Referring physician: _____ date last seen: _____

Primary care physician: _____ date last seen: _____

I hereby authorize the Kids RehabGYM to release health care information necessary to file a claim with the above 3rd party payers and assign benefits payable to the Kids RehabGYM.

Guardian signature: _____ Date: _____