Buffalo Rehab Group

NEW PATIENT INFORMATION FORM

(Please Print and write name how it is shown on your insurance card)

PATIENT INFORMATION

Patient's First name: MI: Last Name:				Date of Birth:
Social Security #:(not required but helpful for ins)		❑ Male ❑ Female		Patient Nickname:
Street address:				
City:	State	Zip Code	Preferred Contact no:	Email Address:
Occupation:	Emergency Contact Name			Emergency Contact phone no.:

Referred to clinic by (please check one box):
❑ Physician ❑ Family ❑ Friend ❑ Close to home/work ❑ Website ❑ Other _____

Referring Physician Name and Phone Number:	Primary Care Physician Name and Phone Number:

INSURANCE INFORMATION
(ALSO COMPLETE NEXT PAGE IF WORKERS COMP OR NO FAULT)

Primary Insurance Plan: (i.e. BCBS)		**Secondary Insurance Plan: (i.e. BCBS)**	
Insured's ID Number:		Insured's ID Number:	
Insured's Policy Group #:		Insured's Policy Group#:	
Insured's Name:		Insured Name:	
Insured's Date of Birth:		Insured's Date of Birth:	
Insured's Address:		Insured's Address:	
Insured's City:		Insured's City:	
Insured's State:		Insured's State:	
Insured's Zip Code:		Insured's Zip Code:	
Relation to Insured:		Relation to Insured:	
Insured's Gender:	M ☐ F ☐	Insured's Gender:	M ☐ F ☐
Insured's Employer:		Insured's Employer:	
Insured's Phone #:		Insured's Phone #:	

ACCIDENT DETAILS- PLEASE COMPLETE IF THIS VISIT IS DUE TO INJURY

Employment related: Y ☐ N ☐	Motor Vehicle Accident related: Y ☐ N ☐	Date of first symptom or accident:

Give details of accident and complete next page if accident related:

I authorize the release of any medical or other information necessary to process insurance claims.
I authorize payment of medical benefits directly to this practice for the services rendered.

Patient/Guardian signature Date

*By providing my e-mail address, I'm authorizing the clinic to send me appointment reminders via e-mail

Please fill out Page 2 if Worker's Compensation or No Fault Case

ONLY COMPLETE IF THIS IS A WORKER'S COMPENSATION OR NO FAULT CASE

Workers Comp Carrier Name:		**No Fault Insurance Name:**	
Insurance Company Address		Insurance Company Address	
Insurance Co City		Insurance Co City	
Insurance Co State		Insurance Co State	
Insurance Co Zip		Insurance Co Zip	
Carrier Case/Claim #		Carrier Case/Claim #	
WCB #		Policy #	
Case Manager Name		Policy Holder Name	
Case Manager Phone #		Adjuster Name	
Employer's Name		Adjuster Phone Number	

I refuse to provide this practice with my personal health insurance information. I am aware that if WC/No Fault denies payment, I am solely responsible for the remainder of the bills. _____Initials