OCI Acct #: _______________ **MIDWEST REHAB** Auth/PreCert required: Y / N
Type of eval: ______________ Pending / Received ________ initials
Date: ____________________

Patient Registration Form

Time/Visits:_____________________

Name: (first)_________________________(middle initial)____ (last)______________________________________
Birth date: _______________________ Age: ________________ **SS#**_________________________________
Address: ____ (city/state/zip) ___________________________
Phone: (home): ___________________ (cell): ___________________ (work): ______________________
May we leave phone messages when necessary: Yes/No Email address: ______________________________

MD Referring____ reports: Y/N
Address: (street/P.O.Box)_____________________________________ (city/state/zip): ______________________
Phone: __________________________ Fax: ________________________ Email:__________________________

Insurance/Payor Source:_________________________ Contact:_____________________________ Reports: Y/N
Address:(street/P.O.Box)________________________________(city/state/zip)_____________________________
Phone: __________________________Fax: ________________________Email: ___________________________
Group/Claim#: ____
Insured (Name): ________________________ (Relationship): ________________(Insured DOB): ______________

Secondary Ins/_________________________________ Attn: _______________________________Reports: Y/N
Address: (street/P.O.Box)_____________________________________(city/state/zip): _______________________
Phone: ____________________________Fax: _______________________Email: __________________________

Emergency Notification/Nearest Relative:
Name: ____Relationship: ______________________________
Address: (street/P.O.Box)_____________________________________ (city/state/zip): _________________________
Phone: _______________________ *Do you want us to share information w/Family members*: Yes/No

Payor: Self: ____ Group Ins: ____ Work Comp: _____ Medicare: _____ Other: _______________________
Group Ins Co_____________________________

Date of current injury: ______________ Injured area: ________________ Last date worked: _______________
Brief description of accident: ____

Case Manager, Company and Name: ____
Reports Y/N phone#___________________________________ Fax #____________________________________
WC Ins ________________ Address: ____________________________________ **Claim # :**___________________

Employer: ____
Address: (street/P.O.Box)___________________________________ (city/state/zip): ___________________________
Occupation: ___________________________Phone: _______________________Fax: _______________________

Have you had **Home Health Services** this year? Y/N Company:____
Have you had **previous OP PT/OT** services this year? Y/N when: ____