



Buckeye Health & Rehabilitation
CONFIDENTIAL PATIENT INFORMATION FORM

This information is needed so we can better serve you. Please fill in **ALL** portions of this form. If you need assistance, please ask our receptionist, and we will be happy to have our Patient Services Representative help you.

First Name: _____ M.I.: _____ Last Name: _____

Date of Birth: _____ Age: _____ Sex: _____ SS#: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone / Pager: _____ E-mail: _____

Occupation: _____ Employer: _____ Work Phone: _____

Employer's Address: _____

Marital Status (Circle One): Married Single Divorce Widow Drivers License #: _____

Spouse's/Parent's Name: _____ Spouse's/Parent's Employer: _____ Work Phone: _____

Spouse/Parent's SS# (cardholder): _____ Spouse/Parent's DOB (cardholder): _____

Nature of Visit (Circle One): Work Injury Auto Accident Personal Injury Other (Please Explain): _____

Are you a Medicare Patient? Yes No Medicare #: _____

Are you a Medicaid (Medical Card) Patient? Yes No Medicaid/Medical Card #: _____

Family Physician: _____ Address: _____ Phone: _____

Other Physicians: _____ Address: _____ Phone: _____

Other Physicians: _____ Address: _____ Phone: _____

Dentist: _____ Address: _____ Phone: _____

Whom may we contact in the case of an emergency?

Name: _____ Phone: _____

Name of nearest friend or relative not living with you: _____ Phone: _____

How did you find out about our facility? (Please circle)

Friend Relative Doctor's Referral Our Sign Flyer Health Matters Penny Pincher Yellow Pages NCT/Newspaper New Mover's Mailings

Other (Please Explain): _____

Whom may we thank for referring you to our facility?

Name: _____ Address: _____ Phone: _____

Who is responsible for this bill? _____ Phone: _____

I will be paying today by: (Please circle): Cash Check Credit Card Other (Please Explain): _____

I have read all the information on this sheet and attest that the above information is true and correct to the best of my knowledge and have completed all of the above questions. I further understand and agree that any and all charges incurred by me in this office and the balance of my account are my sole responsibility, despite any insurance plan, legal involvement, or settlement. I also agree to notify this facility of any changes in my status or the above information as soon as I become aware of such changes.

Patient's Signature: _____ Date: _____

Parent or Guardian: _____ Date: _____

(If patient is a minor)