1049 North Edge Trail
Verona, WI 53593
(608) 845-2100 Phone
(608) 845-2101 Fax
info@stellarrehab.com

PATIENT REGISTRATION FORM

DATE: _____

PATIENT INFORMATION:

PATIENT NAME: _____ DOB: _____
(LAST) (FIRST) (MI)

GENDER: MALE / FEMALE / CHOOSE NOT TO DISCLOSE MARITAL STATUS: SINGLE / MARRIED / WIDOWED / DIVORCED

ADDRESS: _____

_____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

WOULD YOU LIKE A TEXT REMINDER THE BUSINESS DAY BEFORE YOUR APPOINTMENT? (Y)_____ (N)_____

TEXT MESSAGING RATES MAY APPLY

EMERGENCY CONTACT: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS:_____

PHONE: _____(CELL):_____(WORK):_____

POA: (NAME)_____ACTIVATED: (Y)_____ (N)_____

ADDITIONAL FAMILY MEMBERS CONTACT INFORMATION: (IF NECESSARY):_____

NAME_____(PHONE NUMBER):_____

DOCTOR INFORMATION:

REFERRING PHYSICIAN: _____PHONE NUMBER:_____
ADDRESS: _____ FAX NUMBER: _____
LAST DATE SEEN BY ATTENDING/PRIMARY PHYSICIAN:_____
THERAPY ORDERS RECEIVED? YES / NO ORDER DATE: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE PROVIDER: _____
PRIMARY INSURANCE ADDRESS: _____
_____ PHONE : _____
POLICY HOLDER NAME: _____
POLICY NUMBER: _____ GROUP NUMBER: _____
EFFECTIVE DATE: _____ THERAPY COVERAGE: YES / NO CO-PAY: _____

SECONDARY INSURANCE PROVIDER: _____
SECONDARY INSURANCE ADDRESS: _____
_____ PHONE: _____
POLICY HOLDER NAME: _____
POLICY NUMBER: _____ GROUP NUMBER: _____