

REHABILITATION MEDICINE ASSOCIATES
COLUMBIA UNIVERSITY

PATIENT REGISTRATION FORM

NEW PATIENT INFORMATION	INFORMATION UPDATE	TODAY'S DATE: / /
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PATIENT INFORMATION				
PATIENT NAME:	HOSPITAL #	DOB: / /	AGE:	SEX
		DATE OF INJ. / /		M F
STREET:				
CITY:		STATE:	ZIP:	

EMPLOYER INFORMATION				
EMPLOYER NAME:				
STREET:				
CITY:		STATE:	ZIP:	
TEL#: ()				

IN CASE OF EMERGENCY				
CONTACT NAME:				
STREET:				
CITY:		STATE:	ZIP:	
TEL#: ()	RELATIONSHIP:	PARENT	SPOUSE	CHILD FRIEND

INSURANCE INFORMATION						
TYPE OF INSURANCE:	SELF PAY	COMMERCIAL	MEDICARE	MEDICAID	AUTO ACCIDENT	WORKERS COMP.

1st. INSURANCE COMPANY NAME: SEND CLAIMS TO STREET: CITY: STATE: ZIP: TEL #: ()	INSURANCE ID# OR SS #: POLICY#: GROUP#:
OT & PT PREAPPROVAL	
FROM: / / TO: / /	
2st. INSURANCE COMPANY NAME: SEND CLAIMS TO STREET: CITY: STATE: ZIP: TEL #: ()	INSURANCE ID# OR SS #: POLICY#: GROUP#:
OT & PT PREAPPROVAL	
FROM: / / TO: / /	

