IMPACT
Rehab & Wellness

Patient Data Sheet

Please complete this form prior to your first visit.
Also, bring insurance information.

PATIENT INFORMATION

Name: _____
Last First Middle

Date Of Birth: _____ SSN: _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated

Mailing Address: _____
Street City State ZIP

Phone: Home( ) _____ Work ( ) _____ Cell ( ) _____

E-mail: _____ Preferred way to contact you: ☐ Home ☐ Work ☐ Cell

Employer Name: _____ Occupation: _____

Emergency Contact: _____ Phone: _____
Name/Relation

INSURANCE INFORMATION

Are you aware of your Insurance's benefits ☐ Yes ☐ No

Primary Insurance Name: _____ Policy Holder's Name: _____ DOB: _____

Primary Insurance Address: _____ Phone: _____
Street City/State/Zip

Policy ID No. _____ Policy Group No. _____

Secondary Insurance Name: _____ Policy Holder's Name: _____ DOB: _____

Secondary Insurance Address: _____ Phone: _____
Street City/State/Zip

Policy ID No. _____ Policy Group No. _____

Complete next section if patient is a minor.

RESPONSIBLE PARTY INFORMATION

Relation to Patient ☐ Mother ☐ Father ☐ Other

Name: _____ Date Of Birth: _____
Last First Middle

Address: _____ SSN: _____
Street City State ZIP

Phone: Home ( ) _____ Work ( ) _____ Cell ( ) _____

_____ _____
Signature Date

It is the patient's responsibility to notify our office of any changes to your information listed on this form.