Thank you for choosing Beauregard Health System Rehab Services for your needs!

All information is confidential

Name _____ **Patient SSN:** _____

DOB _____ *(circle)* **Male Female Phone** _____

Race: *(circle)* Asian Black Hispanic/Latino White Other: _____ Prefer-to-not-answer

Ethnicity: *(circle)* Chinese Hispanic Native American Non Hispanic Other: _____

Marital Status: *(circle)* **Single Married Divorced Widowed Separated**

Mailing Address _____

City _____ **State** _____ **Zip** _____

Religious Preference_____

Patient's Employment Status? *(circle)* **Full Time Part Time Unemployed**

Employer_____

City_____ **State** _____ **Zip** _____ **Phone** _____

Financial Information

Primary Insurance: _____ **Secondary Insurance:** _____

Insured Name: _____ **Insured Name:** _____

Insured DOB: _____ **Insured DOB:** _____

Policy Number: _____ **Policy Number:** _____

Is the Patient a Veteran or Dependent? *(circle)* **Yes No If yes:**

Sponsor's Name _____ **DOB** _____ **SS** _____

Next of Kin Contact

Relationship to Patient_____

Name _____

Phone_____

Secondary Emergency Contact

Relationship to Patient_____

Name _____

Phone _____

Guarantor Information

(Primary Insurance Holder Information)

****If patient is a minor, complete information for Parent/Guardian***

Primary Name _____ **Relationship to Patient** _____

Primary DOB _____ **Primary SSN** _____

Mailing Address _____

City, State, Zip _____

Phone _____ **Employer** _____

Referring Physician _____

Primary Care Physician _____

Please return this completed form to the Front Desk and begin filling out your Patient Intake packet.