PHYSICAL MEDICINE ASSOCIATES, INC.

PLEASE PRINT NEATLY

NAME: _____
(Last) (First) (MI)

ADDRESS: _____

CITY: _____ ST: _____ ZIP CODE: _____

HOME PHONE: (_____) _____ CELL: (_____) _____

DATE OF BIRTH: _____ SSN: _____ SEX: M F MARITAL STATUS: S M D W DP

EMAIL: _____

RACE: _____ ETHNICITY: HISPANIC/LATINO – ◯ YES ◯ NO

LANGUAGE: _____

EMERGENCY CONTACT: _____ PHONE: (_____) _____

RELATIONSHIP TO PATIENT: _____

PHARMACY: _____ PHONE: (_____) _____

REFERRING PHYSICIAN: _____

PRIMARY INSURANCE OR WORKERS COMP

INSURANCE COMPANY: _____

ID# _____ GROUP # _____

SUBSCRIBER: _____ DOB: _____ SSN: _____

RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE

INSURANCE COMPANY: _____

ID# _____ GROUP # _____

SUBSCRIBER: _____ DOB: _____ SSN: _____

RELATIONSHIP TO PATIENT: _____

I request that payment of authorized benefits be made on my behalf to Physical Medicine Associates, Inc., 7269 Sawmill Rd, Ste 150, Dublin OH 43016, for all services provided to me by Physical Medicine Associates, Inc. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents or my private insurance company any information needed to determine benefits for the services provided by Physical Medicine Associates, Inc. or any related services. I agree to be fully responsible for all lawful debts incurred by myself or my dependents for services rendered, regardless of insurance coverage, benefits, or determinations.

_____

Signature of Patient (or Responsible party) Date