Allied Health Rehab Centers

Cuyahoga Falls ☐
650 Graham Road
Suite 107
44221
(330) 920-1002
(330) 920-0923 Fax

Mogadore ☐
35 N. Cleveland Ave.
Suite C
44260
(330) 628-0736
(330) 628-0739 Fax

Appt. Date: _____ Therapist: _____ Acct.#: _____

Patient Name:		Social Security #:	
Address:		_____Male	_____Female
City:	State:	Zip:	
Phone:	Date of Birth:	Circle: Single Married Divorced Widow Other	
Patient Employer/School Name:		Phone:	
Address:	City:	State:	Zip:

Responsible Person:		Relationship to Patient:	
Resp. Person Address:		City: State:	Zip:
Emergency Contact:	Phone:	Patient's E-Mail: No Billing, Informational Only	

Referring Physician:	Primary Care:

Is Patient's Condition Related to: Auto___ Employment___ Date on Onset/ Injury Date: _____ / _____ / _____

Has patient had chiropractic, physical, occupational or speech therapy this year? Yes___ No___ How Many?? _____
If Yes, Date(s) Seen _____ Where seen ? _____

MEDICARE PATIENTS: Have you had any In-Home / Home Health Care **this year**? Yes___ No___
If Yes, Date(s) Seen _____ By Whom / What Agency ? _____

How did you become aware of our services? Physician___ Patient___ Ad___ Radio___ Website___ School___ Other___

Primary Insurance: Health____ Auto____ Workers' Comp____ Other_____

Name of Insurance:		Phone#:
Policy Holder:	SS#:	Date of Birth:
Policy / ID#:	Group #:	Employer:

Secondary Insurance: Health____ Auto____ Workers' Comp____ Other_____

Name of Insurance:		Phone#:
Policy Holder:	SS#:	Date of Birth:
Policy / ID#:	Group #:	Employer: