

DORA ROBERTS REHABILITATION CENTER  
306 WEST THIRD STREET  
BIG SPRING, TX 79720  
PHONE: (432) 267 3806 FAX (432) 267 3809

PATIENT REGISTRATION FORM

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

SS# \_\_\_\_\_

Marital Status (Circle): Single / Married / Widowed Gender (circle): Male / Female

Mailing Address (Street, City, State, ZIP) \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Employer: \_\_\_\_\_ Wrk Phone#: \_\_\_\_\_

Guardian/Spouse's Name: \_\_\_\_\_

Guardian/Spouse's Employer: \_\_\_\_\_ Wrk Phone#: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone#: \_\_\_\_\_

Referring Provider: \_\_\_\_\_ PCP: \_\_\_\_\_

May we communicate DRRC news or patient billing information to you via e-mail? Y / N  
E-Mail Address \_\_\_\_\_

Are you currently receiving home health? Y / N If yes, what agency? \_\_\_\_\_

INSURANCE AND BILLING INFORMATION

1) Insurance Company: \_\_\_\_\_ ID# \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ PH DOB \_\_\_\_\_ Grp# \_\_\_\_\_

2) Insurance Company: \_\_\_\_\_ ID# \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ PH DOB \_\_\_\_\_ Grp# \_\_\_\_\_

Benefits: Deductible: \_\_\_\_\_ Met: Y / N Coinsurance: \_\_\_\_\_

In Network / Out Network Plan Limitation: \_\_\_\_\_

*Assignment of Insurance Benefits:* I hereby authorize direct payment of benefits to Dora Roberts Rehabilitation Center for services rendered.

*Authorization to Release Information:* I hereby authorize Dora Roberts Rehabilitation Center to release any medical information that may be necessary for continued medical care with my physician or to obtain reimbursement from insurance companies and/or third parties.

*Publications:* I hereby authorize Dora Roberts Rehabilitation Center permission to take photographs & other types of recordings, which may be used for publications and/or presentations. I understand that such information will be completely anonymous.

PATIENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_