ALLIANT Rehab and Sports Therapy

Date: _____

Patient Full Name: _____ **Age:** _____

Sex ____**Male** ____**Female** **Date of Birth:** _____ **SS#:** _____

Address: _____ **City:** _____**State:**_____

Zip: _____ **Home #:**_____ **Cell#:**_____**Work#:**_____

Employer: _____ **DL#:** _____

Email: _____**Preferred method of Contact:** _____

Guarantor if different than above:

Name of INSURED: _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____

Zip: _____ **SS#:** _____ **Employer:** _____

DL#: _____ **Work#:** _____ **Cell#:** _____

Email: _____ **Preferred method of contact:** _____

Emergency Contact Information

Name: _____ **Relationship to Patient:** _____**Cell#:**_____

Authorization for Disclosure of Protected Health Information

I authorize Alliant Rehabilitation & Sports Therapy to disclose protected health information to the following:

Name: _____ **Relationship to Patient:** _____**Cell#:**_____

Prescription-Medicine List

_____ _____

_____ _____

_____ _____

_____ _____