**Ellman**
Rehab Associates
BOARD CERTIFIED

Pain Management • Non-operative Spine Care • EMG/NCS • Sports Medicine

## PATIENT INFORMATION

FIRST NAME: ________________________ MIDDLE: ________ LAST: _____________________ SSN:_______________________

DOB: _______________________________ AGE: ___________ MARITAL STATUS: ________________________ SEX: __________

HOME PHONE: _____________________________________________ WORK PHONE: ____________________________________

HOME ADDRESS: ___________________________________________ CITY/STATE/ZIP: ___________________________________

EMPLOYER NAME: ___________________________________________________________________________________________

EMPLOYER ADDRESS: _______________________________________ CITY/STATE/ZIP: ___________________________________

EMERGENCY CONTACT:_____________________________ PHONE: ___________________________ RELATIONSHIP: __________

REFERRED BY:______________________________________________________________________________________________

ALLERGIC TO ANY MEDICATIONS:___________________ LIST: _________________________________________________

MEDICARE PATIENTS - DATE OF RETIREMENT:_______________________________________________________________________

WORKER'S COMP PATIENTS - DATE OF INJURY: ______________________________________________________________________

AUTO ACCIDENT - DATE OF INJURY: _______________________________________________________________________________

AGENT: _______________________________________________________________________________________________________

**PLEASE BRING INSURANCE CARDS TO FRONT DESK SO THEY MAY BE COPIED**

I AUTHORIZE THE PHYSICIAN TO RELEASE ANY MEDICAL INFORMATION REQUESTED BY REPRESENTATIVES OF LOCAL, STATE AND FEDERAL AGENCIES OR OTHER ORGANIZATIONS OR ENTITIES AS MAY BE REQUIRED BY SAID REPRESENTATIVE FOR PAYMENT OR CLAIMS ARISING OUT OF OFFICE VISIT OR HOSPITAL STAY.

A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS THE ORIGINAL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. I UNDERSTAND THAT ANY OVERPAYMENT ON MY ACCOUNT WILL BE PROMPTLY REFUNDED (THIS DOESN'T APPLY TO ON THE JOB INJURIES).

PATIENT: ____________________________________________________________________ DATE: ______________________________

SIGNED BY: ___________________________________________________________________________________________________

2692 N. Galloway, Suite 402 • Mesquite, TX 75150 • Phone 972.682.3909 • Fax 972.682.9289

# AUTHORIZATION FOR RELEASE OF INFORMATION

(THIS FORM NEEDS TO BE SIGNED FOR THE RELEASE OF MEDICAL RECORDS FROM YOUR OTHER HEALTH CARE PROVIDERS IF NECESSARY)

TO ANY PHYSICIAN, HOSPITAL, CLINIC OR THEIR REPRESENTATIVE

YOU ARE HEREBY AUTHORIZED AND REQUESTED TO DELIVER AND FURNISH TO:

**ELLMAN REHAB ASSOCIATES**

**2692 NORTH GALLOWAY AVENUE, SUITE 402**

**MESQUITE, TX 75150**

**PHONE: 972.682.3909 FAX: 972.682.9289**

All records, written reports, x-rays and any other data or information pertaining to the condition and treatment of:

PATIENT'S NAME:______________________________________________________ DOB:____________________________

DATES OF SERVICE: ALL _________________ FROM:___________________________ TO:_________________________

X______________________________________________________________________ ____________________________

Authorized Signature of Parent or Guardian Date

X____________________________________________________________________________________________________

Witness