REHABILITATION INSTITUTE OF WISCONSIN

Please Print Neatly

Today's Date:__________ Date of Injury: ______________________

How were you referred to RIOW?_________

PATIENT INFORMATION:

Last Name: ______________________ First Name: ______________________ M.I.: ____________

Street Address: ____________________ City: ______________ State:________ Zip: ____________

SS#: __________________________ Date of Birth: __________ Home Phone #: ( ) ____________

Email address: ______________________________________ Cell #: ( ) ________________

Would you like to receive periodic educational e-mails from us? ❑ Yes ❑ No Best way to contact you:__________________

(Please Check) ❑ Male ❑ Female ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

Referring Physician: ______________________ Family Physician: ______________________
Address: ______________________ Address: ______________________
City: ______________ State: _____ Zip Code:_______ Phone #: ( ) ______________________
Phone #: ( ) ______________
Fax #: ( ) ______________

EMPLOYER (or that of parent, if a minor):
Name of Employer: ______________________________ Work Phone #: ( ) ______________________
Employer Address: ____________________ City: ______________ State: ________ Zip: ____________
Occupation: ____

IN CASE OF EMERGENCY, NOTIFY:
Name: ____________________ Home Phone #: ( ) __________ Work Phone #: ( ) ______________
Address: __________________ Cell # ( ) ______________ Relationship: ______________________

INSURANCE INFORMATION:
Primary Insurance: ______________________________________ Phone #: ( ) ______________
Subscriber's Name: __________________ SS #: __________________ DOB: ______________
Group #: ______________________ I.D.#: ______________________________________
Employer (if different than above):____
Employer Address: __________________ City:______________ State: ________ Zip: ____________

Secondary Insurance: ______________________________________ Phone #: ( ) ______________
Subscriber's Name: __________________ SS #: __________________ DOB: ______________
Group #: ______________________ I.D.#: ______________________________________
Employer: ____

Worker's Compensation: ❑ Yes ❑ No

FOR OFFICE USE ONLY:

Claim #: ______________________ Carrier: ______________________
Contact Person: ________________ Address: ______________________
Phone #(s): __________ Fax: __________ City/State/Zip: ______________________

Medicare: ❑ Yes ❑ No **Other Accident**: ❑ Yes ❑ No **Auto Accident**: ❑ Yes ❑ No
Please Specify: ____

FOR OFFICE USE ONLY:
Physician UPIN #:__________________ **NPI #:** ______________ **Therapist**: _______ ❑ **PT** ❑ **OT**
Diagnosis: ____
____
Diagnosis Codes: ____
____