Injury and Health Management Solutions, Inc. Intake/Registration Form

Patient Name:		**Insurance Carrier:**	
Address:		Adjustor:	
		Subscriber Name:	
Home phone:		Address:	
Cell phone:			
Work phone:		Phone:	
DOB:	M or F	Fax:	
Home Email:		Claim #:	
Work Email:		Member ID #:	
Date of Injury:		Group #:	
Diagnosis:		Copay amount:	

Primary Care Doctor:		**Specialist:**	
Facility Name:		Facility Name:	
Address:		Address:	
Phone:		Phone:	
Fax:		Fax:	
Email:		Email:	

Employer if WC:		**Attorney/Other:**	
Contact:		Company:	
Address:		Address:	
Phone:		Phone:	
Fax:		Fax:	
Email:		Email:	

Rehab Counselor:		**Other:**	
Rehab Company:		Company:	
Address:		Address:	
Phone:		Phone:	
Fax:		Fax:	
Email:		Email:	

IN CASE OF EMERGENCY			
Name of local friend/relative:	Relationship to patient:	Home phone number:	Work Phone and/or Cell Phone Number:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to this office. I understand that I am financially responsible for any balance. I also authorize Injury & Health Management Solutions, Inc. or my insurance company to release the information required for processing my claims.

_____ _____

Patient/Guardian Signature Date