SUNSHINE SPINE & PAIN, P.A.

ARKAM REHMAN, M.D.
Physical Medicine & Rehabilitation
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PLEASE PRINT PATIENT INFORMATION: DATE_____

NAME _____ Male____ Female ____
Last first middle

SS# _____ Date of Birth _____ Cell Phone _____

Address: _____ Home Ph _____
Street address

City / State / Zip _____

Mailing Address (if Different) _____

Place of Employment _____

Please Check Single_____ Married _____ Divorced _____ Widow _____ Dependent _____

If Married Spouse Name _____

Spouse SS# _____ **DOB:** _____

Emergency Contact_____ Relationship _____ Phone _____

I give authorization for medical information, lab work results and other test results to be given to the following:
PATIENT ONLY _____ EMERGENCY CONTACT _____ OTHER _____

I give authorization for messages to be left on my answering machine for:
Test results Or prescription information _____ yes No _____

INSURANCE * PLEASE GIVE RECEPTIONIST YOUR INSURANCE CARDS AND PICTURE ID*****

PRIMARY INSURANCE

Insurance Name _____
Policy/ID# _____
Group # _____
Subscriber Name _____
Subscriber DOB _____
Relationship to Patient _____

SECONDARY INSURANCE

Insurance Name _____
Policy/ID # _____
Group # _____
Subscriber Name _____
Subscriber DOB _____
Relationship to Patient _____

AUTO INSURANCE

Insurance Name _____
Claim # _____
Claims Address _____
_____
Date of Accident_____
Contact Name _____
Contact Phone # _____

WORKER'S COMPENSATION

Insurance Name _____
Claim # _____
Claims Address _____
_____
Date of Injury _____
Case Manager _____
Contact Phone # _____