ALEXANDRIA
REHABILITATION
YOUR UPPER EXTREMITY SPECIALIST

Patient Information

NAME Last _____ First _____ MI _____ Date of Birth_____

Current Address _____ City _____ State _____ Zip_____

PHONE Home_____ Work_____ Cell_____

E-Mail Address_____ Preferred Name_____

Permanent Address (if different from above) _____

City_____ State_____ Zip_____

Authorized Individuals

The following people are authorized to discuss my personal health information and coordinate with Alexandria Rehabilitation for evaluation and treatment, including follow up appointments, telephone communication, scheduling appointments and may be contacted in case of an emergency.
(Authorization does not allow requests and/or transferring of records)

Name_____ Relationship_____ Phone Number_____

Name_____ Relationship_____ Phone Number_____

General Information

Referring Doctor_____ Family Doctor_____

Description of Problem_____ Date of Onset_____

Have you had Surgery? Y_____ N_____ If yes, when?_____ Surgeon_____

Was there an accident? Auto_____ Work_____ Other_____ Claim Number_____

Responsible Party

Who is responsible for the account?

NAME Last_____ First_____ MI_____ Relationship to Patient_____

Address_____ City_____ State_____ Zip_____

Employer_____ Work Phone_____ Home Phone_____

Insurance Co_____ Policy Number_____

Insurance Phone_____ Secondary Insurance? Y_____ N_____

THANK YOU FOR CHOOSING ALEXANDRIA REHABILITATION!
PHONE: 320.335.2515 | FAX: 320.335.2717