Chan Soon-Shiong Medical Center at Windber
Rehabilitation Services

600 Somerset Avenue
Windber, PA 15963
814-467-3465
www.windbercare.org

PLEASE FILL OUT COMPLETELY TO ENSURE THAT INSURANCE IS BILLED PROPERLY

PATIENT INFORMATION

PATIENT NAME: _____ SEX: ◯ M ◯ F
ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____ COUNTY: _____
HOME PHONE: _____ CELL PHONE: _____
EMAIL ADDRESS: _____
DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY NUMBER: _____
MARITAL STATUS: ◯ M ◯ D ◯ W ◯ S MAIDEN NAME: _____
VETERAN: ◯ Y ◯ N BRANCH: _____

REFERRING MEDICAL PROVIDER: _____ PROVIDER PHONE: _____
FAMILY MEDICAL PROVIDER: _____ PROVIDER PHONE: _____
REASON FOR REFERRAL/DIAGNOSIS: _____

EMERGENCY CONTACT: _____ RELATIONSHIP TO PATIENT: _____
ADDRESS: _____ PHONE NUMBER: _____

GUARANTOR INFORMATION (INDIVIDUAL RESPONSIBLE FOR BILLING)

NAME: _____ RELATIONSHIP TO PATIENT: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
PHONE NUMBER: _____ SOCIAL SECURITY NUMBER: _____

EMPLOYER NAME: _____
EMPLOYER ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
EMPLOYER PHONE NUMBER: _____
OCCUPATION: _____ ◯ FULL-TIME ◯ PART-TIME

INSURANCE INFORMATION

NAME OF INSURED: _____ RELATIONSHIP TO PATIENT: _____
INSURED DATE OF BIRTH: _____ INSURED SOCIAL SECURITY NUMBER: _____
INSURANCE CARRIER: _____
INSURANCE POLICY NUMBER: _____ GROUP NUMBER: _____

SECONDARY INSURANCE (IF APPLICABLE)

NAME OF INSURED: _____ RELATIONSHIP TO PATIENT: _____
INSURED DATE OF BIRTH: _____ INSURED SOCIAL SECURITY NUMBER: _____
INSURANCE CARRIER: _____
INSURANCE POLICY NUMBER: _____ GROUP NUMBER: _____