Pediatric Rehabilitation Medicine Associates, LLC **Elizabeth Moberg-Wolff, MD**

Patient Information

Name_______________________________________ DOB ___________ Age _____ Race ________ Male / Female

Address ____ City _____________________ ST ______ Zip Code ______________

Primary Care Physician (first ,last) _________________________________Pharmacy (name, #) _____________________________

Primary diagnosis____

Mother's Information

Name ________________________________ DOB _________ SSN _______________________Employer ____________

Address ____ City ___________________ ST ________ Zip Code ______________

Home Phone __________________________Cell Phone __________________________Work Phone ________________________

Email address we can contact you at (kept confidential):____

Father's Information address same as above ☐

Name ________________________________ DOB _________ SSN ______________________Employer _________________

Address ____ City ___________________ ST ________ Zip Code ______________

Home Phone _____________________________ Cell Phone __________________________ Work Phone ____________________

Email address we can contact you at (kept confidential):____

Emergency Contact (name, phone)____

Person who carries Insurance: mother ☐ **father** ☐ **other** ☐ **(fill out below)**

Name ____ DOB _________ Employer ________________________________

Address ____ City ___________________ ST ________ Zip Code ______________

Home Phone _____________________________ Cell Phone ______________________________ Work Phone ________________

Primary Insurance Information: Name of Company ____

Subscriber's Name ____________________________ ID #_______________________ Group # ___________________________

Effective Date ___________________Insurance Co Phone __________________________ Co-Payment _______________________

Secondary Insurance Information: Name of Company ____

Subscriber's Name ____________________________ ID #__________________________ Group # _____________________________

Effective Date _______________________Insurance Co Phone __________________________ Co-Payment __________________

Note: Please bring all insurance information to your appointment The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Pediatric Rehabilitation Medicine Associates, LLC to release any information required to process my claims or communicate within HIPPA guidelines to the referring physician or therapist named by family/patient. Also, to use a photo of the patient in the electronic medical record.

Parent Signature: ____ **Date:** _______________