



## Saint Vincent Catholic Medical Centers Rehabilitation Services Booking Form

**Rehabilitation**

Fax: (212) 604-2046

Phone: (212) 604-8666

*“\*” Fields are **required** as they are key data elements to initiate pre-registration.  
Complete other fields when information is available.*

<b>Patient Name*:</b> _____		<b>Sex*:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	
Last	First		
<b>Date of Birth*:</b>	<b>SSN*:</b>	<b>MRN:</b>	
<b>Patient Address*:</b>			
<b>Home / Work / Cell Telephone #*:</b>			
Guarantor / Legal Guardian:		Best time to call:	
Employer:		Employer Phone:	
Interpreter Needed:		Language:	
Emergency Contact:		Tel #:	Relationship:
<b>PROCEDURE</b>			
<b>Physician*:</b>		Tel #:	Fax #:
Schedule Date:			
Type of Service:	<input type="checkbox"/> PT	<input type="checkbox"/> OT	<input type="checkbox"/> ST
	<input type="checkbox"/> Combo PT & OT	<input type="checkbox"/> PSYCH	
Frequency of Services:	<b>Diagnosis*:</b>	<b>Diagnosis*:</b>	
Duration of Services:	<b>Diagnosis*:</b>	<b>Diagnosis*:</b>	
<b>INSURANCE</b>			
<b>Insurance Company*:</b>			
<b>Policy #*:</b>	Group #:	Ins. Tel #:	
<b>Subscriber Name*:</b>	Relationship to Patient:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse <input type="checkbox"/> Child
Subscriber SSN:	Subscriber DOB:		
Secondary Ins:	Policy #:	Ins. Tel #:	
Subscriber Name:	Relationship to Patient:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse <input type="checkbox"/> Child
Pre-Cert # if Applicable:			
Name of person at Ins. Company issuing Pre-Cert:		Tel #	Date obtained:
<b>Signature and Date</b>			
Date Faxed:		By:	