MICHIGAN ABILITIES CENTER
PHYSICAL MEDICINE AND REHABILITATION
Client Registration Form

Name: _____ Date: _____

Address: _____

Email: _____ Ph: Home:_____ Mobile: _____

Other contact number(s): _____

DOB: _____ Age: _____ Gender: _____

Case Manager Yes No: Name_____ Phone:_____

Emergency contact: Name_____ Phone:_____

Authorized signer for legal documents (& relationship): _____

Spouse/Parent/Legal Guardian: _____ Phone: _____

Address (if different from above): _____

Children/Siblings (& ages): _____

Employer(s) & phone number(s): _____

Employer address: _____

Primary Insurance Company: _____ Insurance Phone: _____

Policy Holder Name: _____Date of Birth: _____

Policy #: _____ Group #: _____ Relationship: _____

Secondary Insurance Company: _____ Insurance Phone: _____

Policy Holder Name: _____Date of Birth: _____

Policy #: _____ Group #: _____ Relationship: _____

Do you allow Michigan Abilities Center Physical Medicine and Rehabilitation to send mail & email correspondence and leave voice messages via home phone & mobile phone regarding your medical appointments Yes____ No____ and your protected health information (PHI) Yes____ No____ (initial yes or no). Please indicate any exclusions: _____

Signature:_____**Date:**_____

Signature of Client / Responsible Party (guardian or parent if under 18 years old)