GARDEN CITY
REHABILITATION CENTER

1150 Reservoir Avenue, Suite 103 • Cranston, RI 02920
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INTAKE FORM

Patient Name: _____ Phone: ( ) _____

SS#: _____ Date of Birth: _____

Address: _____
(Street Address)

_____
(City) (State) (Zip Code)

Email Address: _____
*** ❒ *I give GCRC permission to contact me by email****

Emergency Contact Person: _____

Phone: ( ) _____

Relationship: _____

Policy Holder's SS #: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Policy Holder's Employer: _____

Patient's Occupation: _____

Insurance Type: _____ Insurance Number: _____

Primary Care Physician: _____

Referring Physician: _____

Diagnosis: _____

Is the injury due to an accident? YES NO → AUTO / OTHER

I understand that I am responsible for contacting my insurance company regarding deductibles and co-payments/coinsurance information. I agree to pay all co-pays, deductibles and other charges not covered by my Health/Auto Insurance.

_____ _____
PATIENT SIGNATURE DATE