
**Last Name** _____ **First** _____ **DOB** _____

**Address** _____ **APT/STE** _____

**City**_____ **State** _____ **Zip Code** _____

**Home Phone** _____ Primary Yes __ No __

**Cell Phone** _____ Primary Yes __ No __ **Email** _____

**Appointment Alert Notifications:** Text ___ VM ___ Email ___ (choose one only)

## EMERGENCY CONTACT

Name _____ Relationship _____ Phone _____

## PATIENT WORK INFORMATION

Employer's Name _____ Address _____

City _____ State _____ Zip Code _____

Work Phone _____ Ext. _____ Occupation _____

## REASON FOR VISIT

**Diagnosis** _____ **Date of Injury** _____

**Referring Doctor** _____ **Doctor's Phone** _____

## Authorization to Pay

## CENTER FOR HEALTH ENHANCEMENT AND REHABILITATION (CHEAR)

Assignment of Benefits

I hereby authorize my insurance benefits to be paid directly to CENTER FOR HEALTH ENHANCEMENT AND REHABILITATION (CHEAR) and I understand that I am financially responsible for non-covered services and any amount not paid by my insurance. I understand that CHEAR is not a provider for MEDI-CAL services. I also authorize CHEAR to release any information to process this claim.

**SIGNED** _____ **DATE** _____