RECOVERY TECHNOLOGY L.L.C.

_____

Demographic Information

Date _____

Admission Date _____

Client Name _____ **DOB** _____ **Case #** _____

Gender ☐ Male ☐ Female

☐ Other _____

Address _____

City, State, Zip _____

Phone _____

Emergency Contact _____

Address _____

City, State, Zip _____

Phone _____

Guardian Name _____

Address _____

City, State, Zip _____

Phone _____

Social Security Number _____

Payee Name _____

Address_____

City, State, Zip _____

Phone _____

Primary Clinician _____

Hospital of Choice _____

Address _____

City, State, Zip _____

Phone _____

Allergies/Medical Alerts (In red or Highlight)

_____

_____

Client Name_____ **Case #**_____

Primary Care Physician:

Physician Name: _____

Address: _____

City, State, Zip Code: _____

Phone: _____ FAX _____

Primary Insurance _____

Policy Group # _____

Policy Holder _____

Policy Holder's DOB _____

Policy Holder's SSN _____

Relationship to Insured _____

Secondary Insurance _____

Policy Group # _____

Policy Holder _____

Policy Holder's DOB _____

Policy Holder's SSN _____

Relationship to Insured _____

Race: ◯ White ◯ African American ◯ Native American ◯ Hispanic

◯ Multi-Racial ◯ Asian/Pacific Islander ◯ Arab American

◯ Other: _____