



## Parent's Information Form for Minors

Date: \_\_\_\_\_ P.T.: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Type of Referral: WC Priv. Ins. (PPO) MC Lien Other: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

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**PATIENT'S NAME:** \_\_\_\_\_

SSN#: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SEX: \_\_\_\_\_

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### PARENT/GUARDIAN INFORMATION:

**Father's / Guardian's Name:** \_\_\_\_\_

SSN#: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Billing Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ FAX #: \_\_\_\_\_ Other #s: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Mother's / Guardian's Name:** \_\_\_\_\_

SSN#: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Billing Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ FAX #: \_\_\_\_\_ Other #s: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

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Other Information:

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I hereby authorize payment directly to Rehab United of all benefits otherwise payable to me for services rendered by Rehab United but not to exceed the reasonable and customary charges for these services. I understand that I am responsible for charges not covered by my insurance or lien and for the accuracy of the information stated above.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_