PARKWAY
RECOVERY CARE

FACE SHEET

Today's date:	Date of Surgery:	Surgeon:
Allergies:		Procedure:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Admission Date:

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Social Security #:	Birth date:	Age:	Sex: ❑ M ❑ F

Street address:	Cell Phone #: ( )	Home phone #: ( )

Email:	City:	State:	ZIP Code:

INSURANCE INFORMATION

Subscriber's name:	Birth date: / /	Group #:	Policy #:	Subscriber's S.S. #:

Occupation:	Employer:	Employer address:	Employer phone #: ( )

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group #:	Policy #:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my know ledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Parkw ay Recovery Care Center or insurance company to release any information required to process my claims.

Patient/Guardian Signature *Date*

Witness Signature *Date*

Attach a copy of all insurance cards and driver's license to face sheet