3501 S. Soncy Rd. Suite 137 Amarillo, Texas 79119
806-331-6084 806-331-6085 (fax)

PATIENT INFORMATION

Patient Name: _____

Birth Date: _____ Gender: _____

Primary Care Physician: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Alternate Phone: _____

Email Address: _____

Emergency Contact: _____

Emergency Contact Phone: _____

Medicare Number: _____

Primary Insurance (if other than Medicare): _____

Primary Insurance Policy Number: _____

Secondary Insurance: _____

Secondary Insurance Policy Number: _____

CONSENT TO TREAT

I, _____, consent to be treated by Catalyst Rehabilitation personnel in my current residence.

_____ _____
Patient Signature Date

_____ _____
Guarantor Signature (if applicable) Date