RANCHO LOS AMIGOS
NATIONAL REHABILITATION CENTER
Rancho Rising 2020

NEW PATIENT INFORMATION FORM
For Referrals to OutpatientTherapy

LAST NAME | FIRST NAME | M.I

ADDRESS

CITY | STATE | ZIP CODE

TELEPHONE (HOME) | TELEPHONE (MOBILE) | SOCIAL SECURITY #

DATE OF BIRTH | GENDER | RACE | LANGUAGE

BIRTH PLACE

☐ CITIZEN
☐ RESIDENT
☐ UNDOCUMENTED

MOTHER'S MAIDEN NAME

MARITAL STATUS | NAME OF SPOUSE

EMERGENCY CONTACT NAME | RELATIONSHIP

ADDRESS | TELEPHONE NUMBER

INSURANCE:

☐ MEDI-CAL # | MEDI-CAL ISSUE DATE | ☐ MEDICARE #

☐ OTHER INSURANCE

<u>Please return this form and the MD Referral form to</u>:

Rancho Outpatient Therapy Office
Telephone: (562) 385-7111, ext.56536 Fax: (562) 385-7826
Email: OutpatientTherapy@dhs.lacounty.gov (please send encrypted)