RANCHO LOS AMIGOS
NATIONAL REHABILITATION CENTER

Outpatient Medicine Referral

Patient Information

Date: _____

Service/clinic name( )_____

Last Name:_____First Name: _____

Address:_____

City:_____ State: _____Zip Code:_____

Home Phone:_____Cell:_____email:_____

SSN#_____

Birth Date: _____ Sex:_____ Race:_____

Birth Place:_____ Language:_____

Citizen ( ) Resident ( ) Undocumented ( )

Marital Status: _____ Name of Spouse:_____

Mother's Maiden Last Name:_____

Next of Kin:_____ Phone Number: _____

Relationship:_____email: _____

Insurance: ( ) Medi-Cal CIN#:_____

( ) Medi-Care Hic#:_____ ( ) A:_____ ( ) B:_____

( ) No coverage/Self Pay/ LOA needed:_____

( ) Private Insurance/Name:_____

Member ID#: _____ Contact phone#: _____

Claims Address: _____

City:_____ State:_____ Zip Code: _____