IF YOU HAVE BEEN SEEN AT ANY UNITY HEALTHCARE PRACTICE IN THE PAST, IT IS NOT NECESSARY FOR YOU TO COMPLETE THIS FORM.

This information is necessary to add you into the Unity Healthcare system as a new patient.
Please fill this page out entirely.

Patient Name: ______________________ **SSN:** ______________

Primary Insurance Company: ______________________
Name of Policy Holder: ______________ **Date of Birth:** ______________
Relationship to Patient: ______________________
Social Security Number: ______________________
Address: ______________________
City: ______________ **State:** ________ **Zip:** ________
Employer: ______________________
Phone: Home: ____________ **Work:** ____________ **Cell:** ____________
Email Address: ______________________

Secondary Insurance Company: ______________________
Name of Policy Holder: ______________ **Date of Birth:** ______________
Relationship to Patient: ______________________
Social Security Number: ______________________
Address: ______________________
City: ______________ **State:** ________ **Zip:** ________
Employer: ______________________
Phone: Home: ____________ **Work:** ____________ **Cell:** ____________
Email Address: ______________________

1411 S. Creasy Lane, Suite 100 | Lafayette, IN 47905 | Phone: 765.447.5552 | Fax: 765.449.1054
3451 Wyndham Way, Suite D | West Lafayette, IN 47906 | Phone: 765.446.5250 | Fax: 765.446.5208
www.lafayetterehabilitation.com