RIVERGARDEN | Rehab
PERSONALIZED CARE WITH EXCEPTIONAL RESULTS

OUTPATIENT/ CLIENT INFORMATION FORM

<table>
<tr><td colspan="3">Last Name</td><td colspan="2">First</td><td>MI</td><td colspan="2">Social Security Number
________- ______ - ________</td></tr>
<tr><td colspan="3">Permanent Address</td><td colspan="2">City</td><td>State</td><td>Zip</td><td>Phone</td></tr>
<tr><td>Date Of Birth
/ /</td><td>Age</td><td>Race</td><td>Sex</td><td>Marital Status</td><td colspan="3">Spouse's Name (if applicable)</td></tr>
<tr><td colspan="2">Medicare #</td><td colspan="4">Do you have other insurance?
☐ Yes ☐ No ☐ Not Sure</td><td colspan="2">Policy #:</td></tr>
<tr><td colspan="2">Other Insurance Company</td><td colspan="4">Address</td><td colspan="2">Phone</td></tr>
<tr><td colspan="2">Physician's Name</td><td colspan="4">Address</td><td colspan="2">Phone</td></tr>
<tr><td colspan="3">In Case Of Emergency Notify</td><td colspan="3">Relationship</td><td colspan="2">Phone</td></tr>
</table>