



TaylorRehab
physical therapy
Patient Information Form

Name: _____ **S.S.#** _____
Last Name, First Name M.I.

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: _____
Home Work Cell

Sex: Male Female **Age:** _____ **Birthdate:** _____

Marital Status: Single Married Widowed Separated Divorced

Patient Occupation: _____ **Employer:** _____

Business Address: _____

Emergency Contact in Case of an Emergency:

Name: _____ **Phone:** _____

Referring Physician: _____ **Date of Last Visit:** _____

Reason for Today's Appointment: _____

Date of Injury / Onset of Illness: _____

Current Medications: _____

Medical History: (Please include surgeries, heart condition, diabetes, etc.) _____

Whom May we thank for this referral?: (i.e. Physician referral, friend, website, newspaper add, etc) _____

I, the undersigned (or my dependant), certify that I have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Taylor Rehab Inc. All insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid for by insurance. I hereby authorize Taylor Rehab to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party Relationship to Patient Date