TaylorRehab
physical therapy
www.taylor-rehab.com

# PATIENT INFORMATION FORM

Name: (Last) _____ (First) _____ (M.I.) ___ SS# _____

Address: _____

City: _____State:_____ZipCode: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Sex: Male Female Birth Date: _____ Email: _____

Marital Status: Single Married Widowed Separated Divorced

Patient Occupation_____ Employer:_____

Emergency Contact: Name: _____ Phone:_____

Referring Physician: _____ Date of Last Visit: _____

Body Part Being Treated: _____

| | | | |
|---|---|---|---|
| Have you had any Home Health Care services? | YES/NO | Injured at work? | YES/NO |
| Have you had any Chiropractic services? | YES/NO | Related to Auto Accident? | YES/NO |
| Have you had surgery for this injury | YES/NO | Date of surgery _____ | |

Date of Injury/Onset of Illness: _____

Current Medications: _____

_____

Medical History: (please include surgeries, heart conditions, diabetes, etc.) _____

_____

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

I, the undersigned (or responsible party), certify that I have insurance coverage with 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. Less than 24 hour notice for cancellations may result in a fee which I am responsible for; in addition, a $25.00 fee will be charged for all "no shows". Administrative costs in connection with collection proceedings, an interest of 1.5% per month and reasonable attorney fees may also be charged. 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

114 Welton Way Suite B Mooresville NC 28117 704.660.6551 t 704.660.9894 f
167 Gateway Boulevard Mooresville NC 28117 704.658.1095 t 704.658.1097 f