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. If your account is sent to our collection agency, in addition to paying 100% of your balance, you will also be charged up to 40% of the collection agency's fees as well as any reasonable attorney fees that may 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