



# REHAB PARTNERS

## PATIENT INFORMATION

Date \_\_\_\_\_

Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Single  Married  Widowed  Divorced

Patient Social Security # \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_

Employer's Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Spouse's Birthdate \_\_\_\_\_ SSN \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

If Student, name of school \_\_\_\_\_

If Student, what sports do you participate \_\_\_\_\_

Referring Physician \_\_\_\_\_

When is your next appointment with the physician? \_\_\_\_\_

Date of Injury or onset of symptoms \_\_\_\_\_

## PHONE NUMBERS

Home \_\_\_\_\_ Work \_\_\_\_\_

### IN CASE OF EMERGENCY, CONTACT

Name \_\_\_\_\_

Home \_\_\_\_\_ Work \_\_\_\_\_

## INSURANCE

Who is responsible for this account?  
\_\_\_\_\_

Relationship to patient  Self  Spouse  
 Parent  Other

Subscriber's Name \_\_\_\_\_

Subscribers Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birthdate of cardholder \_\_\_\_\_

SS# of Cardholder \_\_\_\_\_

Is patient covered by additional insurance?  Y  N

Subscriber's Name \_\_\_\_\_

Subscriber's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to patient  Self  Spouse  Child

Was this a motor vehicle accident?  Y  N

If yes, State where accident occurred \_\_\_\_\_

Insurance Company \_\_\_\_\_

Adjuster's Name \_\_\_\_\_

Adjuster's Phone# \_\_\_\_\_

Do you have an attorney?  Y  N

If yes, name of attorney \_\_\_\_\_

Attorney's Phone # \_\_\_\_\_

Is this accident related to work?  Y  N

If yes, name of your adjuster \_\_\_\_\_

Adjuster's Phone \_\_\_\_\_

## MEDICAL HISTORY

Do you have any heart problems?  Y  N

If yes, explain \_\_\_\_\_

Do you have any other medical problems?  Y  N

If yes, explain \_\_\_\_\_

**How did you hear about Rehab Partners?**

Physician     Friend/Relative     TV     Radio     Newspaper     Other

I hereby authorize Rehab Partners, P.C. to furnish information to insurance carriers concerning my illness and treatments and hereby assign to Rehab Partners, P.C. all payments for physical therapy services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. I agree to pay all costs of collection, including a reasonable attorney's fee, should this account be placed with an attorney for collection.

\*NOTE: When making appointments, remember this time was set aside for you. If you can not keep your appointment, please call and cancel.

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

\*REMEMBER, insurance is there to help reduce the cost of treatments - not eliminate it.

**WORKER'S COMPENSATION PATIENTS ONLY**

Physical therapy is being provided to me as prescribed treatment for a work-related injury. I hereby authorize Rehab Partners, P.C. to furnish information to my employer and/or worker's compensation carriers concerning my injury and treatments.

I understand Rehab Partner, P.C. is responsible for notifying my adjuster, case manager, and doctor if I fail to meet my prescribed number of treatments each week. I understand my attendance is mandatory unless excused by my case manager, doctor, or therapist. It is my responsibility to be on time and give my best effort.

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_