TheraCare Rehab
TheraCare PHYSICAL THERAPY

PATIENT INFORMATION

Today's date ____________ SSN # __________________________ DOB _____________ AGE ______ SEX ________

PATIENT'S NAME________________________________ ADDRESS ____

CITY _____________________ STATE _______ ZIP ____________ PHONE # _______________________________

EMPLOYER : _____________________________ADDRESS ____________________PHONE # ___________________

PATIENT'S RELATION TO INSURED (please circle one): SELF SPOUSE OTHER :___________________________

NAME & ADDRESS OF THE INSURED: ____

IS CONDITION RELATED TO : ◯ EMPLOYMENT ; ◯ AUTO ; ◯ OTHER ; DATE OF ACCIDENT/INJURY_________

HAVE YOU BEEN OFF WORK DUE TO THIS INJURY : YES or NO, IF SO FROM _____________TO__________________

BRIEF DESCRIPTION OF PAIN OR INJURY OR ACCIDENT :

____

____

____

HAVE YOU HAD /HAVING THERAPY ELSEWHERE : YES ___or NO _______ IF YES, WHEN?________________________

WHERE____

HOME CARE ________________OUT PATIENT ____________________OTHER ______________________________

IN CASE OF EMERGENCY PLEASE LIST A FRIEND OR RELATIVE TO NOTIFY: ________________________________

PHONE # :______________________________________RELATIONSHIP_______________________________________

HOW DID YOU HEAR ABOUT US: _____**DOCTOR** _____ **YELLOW PAGE** ____**FRIEND** ____**INTERNET** ____ **OTHER** ______

IF DOCTOR REFERRED: NAME ________________________________ PHONE ______________________________

ADDRESS ______________________________ CITY _______________________ STATE _______ ZIP ____________

INSURANCE INFORMATION

DO YOU HAVE MEDICARE, IF SO MC # _________________________IS THIS PRIMARY: YES OR NO (CIRCLE ONE)

OTHER INSURANCE COMPANY ____________________________________ PHONE # ________________________

ADDRESS _________________________________ CITY ___________________ STATE _______ ZIP _____________

INSURED'S NAME: _______________________________D.O.B _______ INSURED'S SS# _____________________

ID OR CLAIM # ____ GROUP # ___________________________________

IS THERE ANY HEALTH BENEFIT PLAN? YES or NO IF SO PLEASE SPECIFY __________________________________

I authorize any holder of medical information about me to be released to my insurance company or to its intermediaries, any information needed for this release or related claim. I request that payment of authorized benefits be made on my behalf. I assign this to Physical Therapy office and authorize them to submit a claim on my behalf.

PATIENT'S SIGNATURE:
(OR Legal Guardian /Responsible Party) ___________________________Date: _________________

42456 Cherry Hill Road, Canton MI 48187-3401, Ph: 734 844 1478, Fax: 734 468 1444
www.theracarerehab.com