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www.totalrehab-pt.com

1) Patient Information

Patient Name: First _____ MI. _____ Last: _____

Street Address: _____ City: _____

State: _____ Zip: _____

Email Address (for appointment reminders): _____

Phone: Home _____ Work _____ Cell _____

Date of Birth: _____ Sex: Male/Female Social Security Number: _____

Employer: _____ Employer Address: _____

Employment Status: Full-time/Part-time/Unemployed/Student Occupation: _____

2) Insured Information (this is the person who is primarily covered under your insurance)

Name: _____ Date of Birth: _____

Employer: _____ Employer City & State: _____

3) Billing Address (if different than the Patient Information listed above)

Name: _____ Street Address: _____

City: _____ State: _____ Zip: _____

4) Workman Compensation Information or Motor Vehicle Accident Information (if applicable)

Employer Contact: _____ Phone: _____

Case Manager: _____ Phone: _____

Date of Injury: _____ Claim Number: _____

I have read and agree to the Privacy Practices (HIPAA) of Total Rehab.

Signature _____

Date _____

I have read and agree to the Financial Considerations for Service at Total Rehab.

Signature _____

Date _____