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12498 Highway F62 East  
Sully, Iowa 50251

Phone: 641-594-3303  
Fax: 641-236-4316

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