Rehab Medical Center
1793 W. Hillsborough Ave.
Tampa, FL 33603
Ph: 813-876-7373 • Fax: 813-876-7375

PATIENT COVER SHEET

W/C

NAME: _____ **DATE:** _____/_____/_____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIPCODE:** _____

HOME # (_____) _____-_____ **CELL # (_____)** _____-_____ **WORK # (_____)** _____-_____

S.S # _____-_____-_____ **DOB:** _____/_____/_____ **AGE:** _____ **[ ] MALE** **[ ] FEMALE**

MARITAL STATUS: **[ ] SINGLE** **[ ] MARRIED** **[ ] DIVORCED** **[ ] WIDOW** **[ ] OTHER** _____

EMPLOYMENT STATUS: **[ ] FULL TIME** **[ ] PART TIME** **[ ] RETIRED** **[ ] NOT EMPLOYED** **[ ] OTHER** _____

EMERGENCY CONTACT: _____ **PHONE # (_____)** _____-_____

ADDRESS: _____ **RELATIONSHIP TO PATIENT:** _____

INSURANCE INFORMATION

INSURANCE COMPANY:

_____

ADDRESS: _____ **PHONE # (_____)** _____-_____

W/C CASE # _____ **DATE OF ACCIDENT** _____/_____/_____

ADJ NAME: _____ **PHONE # (_____)** _____-_____ **FAX # (_____)** _____-_____

SECONDARY INSURANCE COMPANY:

_____

ADDRESS: _____ **PHONE # (_____)** _____-_____

PRIMARY INSURED _____ **RELATIONSHIP TO PATIENT:** _____

ADDRESS: _____ **PHONE # (_____)** _____-_____

DOB: _____/_____/_____ **MEMBER ID#** _____ **GROUP#** _____

REFERRED BY: _____ **PHONE # (_____)** _____-_____

REPRESENTED BY: _____ **PHONE # (_____)** _____-_____

ATTORNEY: _____ **PHONE # (_____)** _____-_____ **FAX: (_____)** _____-_____

INSURANCE MEDICAL RELEASE / ASSIGNMENT: I hereby authorize A+ Rehab Medical Center to release any medical or other necessary information to my insurance carrier and/or attorney representing me in order to process my claims regarding my injury and treatments. I also authorize assignment and direct my insurance carrier to issue payment of medical benefits for services provided to A+ Rehab Medical Center. I understand that I am financially responsible for any charges not covered by my insurance.

PATIENT SIGNATURE _____ **DATE** _____/_____/_____