AIM REHAB SERVICES INC
Quality Therapy in Motion

PATIENT INFORMATION FORM

Section I **PATIENT INFORMATION** **DATE**_____

Last Name: _____First Name:_____Sex: F:_____M:_____

Address:_____City:_____State:_____Zip:_____

Phone: (_____)_____ Cell Phone (_____)_____Work (_____)_____

Date of Birth_____Social Security Number_____

Check Appropriate Box: ☐Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Whom may we thank for referring you?_____

Person to contact in case of emergency_____Phone_____

Relationship to Patient: _____ Patient's email:_____

Section II **PHYSICIAN INFORMATION**

Name:_____Phone:_____

Address:_____Suite:_____Fax:_____

City:_____State_____Zipcode:_____NPI:_____

(For office use only)

Section III **Insurance Information**

Primary Insurance_____Phone:_____Fax:_____

Billing Address:_____City:_____State:_____Zipcode:_____

Contract #:_____Group:_____

Secondary Insurance:_____Phone:_____Fax:_____

Billing Address:_____City:_____State:_____Zipcode:_____

Contract #:_____Group:_____