PATIENT REGISTRATION FORM

PATIENT INFORMATION

Area of Injury to Be Treated_____ Today's Date _____

Payment Method _____ Self Pay _____ Insurance _____Auto _____ Worker's Comp _____ Other _____

First Name_____ MI _____ Last Name _____

Street Address:_____ Apt/Unit_____

City _____ State _____ Zip _____

Home Phone _____ Work Phone_____ Cell Phone_____

_____Male _____Female Marital Status _____ Married _____Single _____Divorced

Date of Birth _____ E-Mail: _____

Best Way to Contact: __ Email __ Cell Phone __ Home Phone Email/Phone *(if different)* _____

Emergency Contact Information

Emergency Contact Name _____ Phone number: _____

Street Address:_____ Apt/Unit_____

City _____ State _____ Zip _____

Home Phone _____ Work Phone_____ Cell Phone_____

Relationship to Patient _____

Physician Information

Primary Care Physician Name _____

Referring Physician Name *(if different)* _____

Have you had physical therapy before? ___ No ___ Yes If yes, when? _____

Medicare Only: Are you currently, or have you recently had any home health services? _____ No _____ Yes

If yes; Are you still receiving services? _____ No _____Yes ***If no***, when were you discharged? _____

INSURANCE INFORMATION

Primary Health Insurance Information **Insurance Carrier** _____

Member ID#_____ Group Number _____

Policy Holder Name _____ Policy Holder Date of Birth _____

Relationship to Patient _____ Policy Holder Phone # _____

Policy Holder Address (*if Different from Patient)* _____ Apt/Unit_____

City _____ State _____ Zip _____

Secondary Health Insurance Information **Insurance Carrier** _____

Member ID#_____ Group Number _____

Policy Holder Name _____ Policy Holder Date of Birth _____

Relationship to patient _____ Policy Holder Phone # _____

Policy Holder Address (*if Different from Patient)* _____ Apt/Unit_____

City _____ State _____ Zip _____

WORKER'S COMP / AUTO INFORMATION *(if applicable)*

Claim # _____ Date of Injury _____

Insurance_____ Adjuster Name _____

Adjuster Phone _____ Adjuster Fax _____ Adjuster Email _____

Attorney Name _____Unit/Suite_____

Attorney Address _____

City _____ State _____ Zip _____

Attorney Phone _____ Attorney Fax _____ Attorney Email _____

Employer Information ***(For all Worker's Comp)*** **Occupation**_____

Employer _____

Address _____Unit/Suite_____

City _____ State _____ Zip _____

OTHER

How did you hear about us? _____

If you are a returning patient, what brought you back to us? _____

CONSENT TO TREATMENT

I hereby authorize the professional staff at _____ Physical Therapy to examine and treat me with physical therapy for the injury I have been referred here for or referred myself to.

_____ _____

Patient Signature Date

_____ _____

Patient Printed Name Staff Witness Signature

_____ _____

Parent or Guardian Signature (if under 18) Date

_____ _____

Parent or Guardian Printed Name Staff Witness Signature