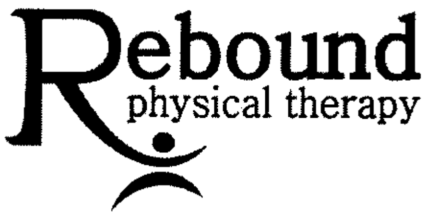

PATIENT REGISTRATION FORMS

please fill out all forms and return to the front desk when completed

Patient Name: ______________________ Gender: ☐ Male ☐ Female

Date of Birth: __________ Age: ________ Social Security #: ______________

Address: ______________________ City: __________ State: ______ Zip: __________

Home Phone #: ______________________ Cell Phone #: ______________________

Employer: ______________________ Employer's Phone #: ______________________

If patient is a minor, please list the following information regarding the responsible party:

→ Name: ______________ DOB: __________ Relationship to Patient: ______________

Emergency Contact/Relationship: ______________________ Telephone Number: ______________

Email address: ____

Would you like to receive appointment reminders via ☐ Email? ☐ Text? ☐ Voice Call?

Do you have a referral from your PCP or an MD? ☐ Yes ☐ No Referring Doctor: ______________

Have you had any other physical therapy treatment this year? ☐ Yes ☐ No If yes, where? ______________

Are you seeking physical therapy because of a work-related injury or accident? ☐ Yes ☐ No

→ If yes, please fill out the following: Employer: ______________________ Phone: ______________

Claim #: ______________ Adjuster Name/Number: ______________________

Are you seeking physical therapy because of a Motor Vehicle Accident? ☐ Yes ☐ No

→ If yes, are we billing an auto insurance? ☐ Yes ☐ No Auto insurance name: ______________

Claim #: ______________ Adjuster Name/Number: ______________________

Insurance Information: *(to be completed even if insurance cards are on file)*

Primary Insurance:

Insurance Co Name: ______________________

Policy Holder: ______________________

Policy Holder DOB: ______________________

Policy ID Number: ______________________

Group Number: ______________________

Relationship to Patient: ______________________

Secondary Insurance:

Insurance Co Name: ______________________

Policy Holder: ______________________

Policy Holder DOB: ______________________

Policy ID Number: ______________________

Group Number: ______________________

Relationship to Patient: ______________________

IF YOU HAVE MEDICARE, ARE YOU CURRENTLY RECEIVING, OR HAVE YOU HAD HOME HEALTH CARE OR STAYED IN AN INPATIENT FACILITY WITHIN THE LAST 30 DAYS? ☐ YES ☐ NO