Physical Therapy Registration Information

First Name: _____Last Name: _____

Address: _____ City _____ State_____ Zip_____

Cell Phone: _____ Home Phone: _____Work Phone: _____

Soc. Sec. #_____ Driver's License #_____

Marital Status: ❑Married ❑Single ❑Divorced ❑Widow(ed)

Sex: ❑Male ❑Female Date of Birth: _____ EMAIL: _____

If the patient is a minor, who is the responsible party & relationship? _____

Occupation _____ Employer _____

***Emergency Contact Name: _____Phone#_____**

***Referring Physician/Physician Assistant? _____Office#_____**

Is this condition: ❑Job related? ❑Auto Accident? ❑Not from a job related injury or auto accident

If job related or Auto Accident, then date of accident ___/___/___, Adjuster: _____ Phone: _____

Primary Insurance

Medicare or Medicare Advantage patients skip questions 1-3, & go to secondary insurance below.

Insurance:_____ ID#_____

Please answer the next 3 questions if the patient is not the "primary insured" (also called the "main subscriber" or "card holder").

1. ***Card Holder's Name:_____**
2. **Card Holder's Date of Birth: _____**
3. **How is the patient related to the Card Holder? ❑Spouse ❑Child**

Secondary Insurance

Insurance:_____ ID#_____

Whom may we thank for referring you to us? _____