Patient Registration

Intial Eval Date _____ Time_____ Therapist_____ Date of Script _____

Patient Information :

First Name_____ MI_____ Last Name_____

Local Address_____City_____ ST_____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone_____

Sex ___ M ___F DOB____/____/_____ SSN:_____--_____--_____ E-mail_____

Referring Physician _____ Physicians Phone _____

Physician Address_____How did you hear about ProFormance? _____

Injury or D.X. Code _____ Surgery Date _____

Emergency Contact Name_____ Relationship _____ Phone _____

Guarantor/Responsible Party : (PERSON RESPONSIBLE FOR PAYMENT OTHER THAN PATIENT)

Name_____ Phone (____)_____

Address_____

Sex ___M ____F **DOB___/____/____** Relationship to patient _____ E-mail _____

Primary Insurance Company : Please Provide Your Insurance Card to Receptionist ____ Commercial _____ Medicare

Insurance Company _____Primary Subscriber:_____Relationship to patient_____

I.D.# _____ Group #_____Subscriber's DOB _____

Address _____ Phone_____

Secondary Insurance Company : Insurance Company _____ Address_____

Subscriber Name_____ Relationship to patient_____

ID #_____ Group#_____ Subscriber's DOB _____

Worker's Compensation Information : Accident Type: ___ Auto ___ Work ___Other_____ Injury Date:_____

Company Name:_____ Company Phone:_____

Adjuster:_____ Phone:_____ Fax:_____

Claim/Case Number:_____ Claim/Case Manager:_____ Phone:_____

Fax:_____

Attorney:_____ Address:_____

Phone:_____ Fax:_____