PATIENT REGISTRATION **TODAY'S DATE _____**

Patient Name: _____ DOB: _____

Mailing Address: _____City: _____Zip:_____

Marital Status: S [] M [] D [] W [] Male [] Female [] Non-Binary []

Phone: _____Cell:_____ Work #: _____

Referring Physician: _____PCP: _____

Employer: _____Occupation: _____

Spouse or Parent Name: _____Phone: _____

Person Responsible for bill if not above named: _____

Emergency Contact: _____Phone: _____

Where did you hear about our clinic? _____

INSURANCE/ID:
*PLEASE PROVIDE YOUR **INSURANCE CARD(S** **AND** **PICTURE ID CARD.** Copies will be scanned into your chart for billing purposes and identification.

***Prior Physical Therapy Treatment used for this Calendar Year: _____**

WORKER'S COMPENSATION INSURANCE INFORMATION (if applicable)

Employer: _____Claim Manager:_____ Phone: _____

W/C Carrier: _____Claim #: _____DOI: _____

Physical Therapy visits used since claim opened: _____

MOTOR VEHICLE ACCIDENT/LIBIALITY INSURANCE INFORMATION (if applicable)

Policy Holder Name: _____Auto Insurance:_____

Claim #: _____DOI: _____ Attorney: _____

Adjustor: _____Phone: _____