

Patient Registration Form



For Office Use Only: Acct# Start / Restart Date Prescription Date: Therapist

PERSONAL INFORMATION

Patient Name First Middle Initial Last SS# Date of Birth MM / DD / YY

Age

Address Street, PO Box Apt# Sex Male Female Status Single Married Other (Circle One) (Circle One)

City State Zip Code

Patient's Employer / School

Home Phone () Cell

Address Street, PO Box Suite#

Work Phone ()

City State Zip Code

Email Address

Parent or Spouse Name (Circle One)

Patient's Occupation / Grade

Address (if different from above) Street, PO Box Apt#

Emergency Contact

Phone ()

City State Zip Code

Referring Physician: Date Last Seen By Physician:

Reason being seen / Body Part:

Have you had surgery for this problem? Yes or No Date of Surgery:

Work Related: Yes or No (circle one) Cause of Injury: Date of Injury:

Motor Vehicle Accident: Yes or No State of Accident: Date of Accident:

Have you received Home Health Care OR Physical Therapy in the past year? Yes or No (circle one)

If yes, have you been released from care? Yes or No (circle one)

Number of visits used for Home Health Number of visits used for PT

Consent for Treatment. Authorization to Release Payment and Information. Our Payment Policy.

Signature Date

Note. If you are 18 years of age or younger, a parent or guardian must sign this patient registration form on your behalf

Additional Insurance Information Sheet

Insurance carriers are requiring specific information to process and issue payment for claims received from our office. Please fill in the following information in its entirety. If this information is not provided and your insurance company denies payment due to the omission of this information, payment of those charges will be your responsibility. Thank you for your cooperation in this process.

Date _____ Patient's Name _____ Account # _____

Insured Party: (if different from the patient)

Name: _____ Relationship to Patient: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Work: _____ Cell: _____
Date of Birth: _____ Sex: Male or Female SS#: _____
Employer: _____

Insurance Information: (Office only)

Primary Insurance Company: _____ Ins Claim Adj / Verifier: _____
Phone: _____ Fax: _____ Policy Effective Date: ___/___/___
ID or Claim #: _____ Group #: _____ Group Name: _____
Verify/Auth Date: ___/___/___ Auth #: _____ # of Visits Authorized: _____ Auth Exp Date: ___/___/___
Deductible: Single \$ _____ Met \$ _____ Family \$ _____ Met \$ _____
OOP: Single \$ _____ Met \$ _____ Family \$ _____ Met \$ _____
Deductible included in the OOP amount: YES or NO DME _____
Patient Percentage: _____ OR Copay: _____ Script Required: YES or NO
Max Visits Allowed: _____ # of Visits used: _____ Max \$ Amt Allowed: _____
Precertification Required: YES or NO ACN Certification: YES or NO
Comments: _____

Secondary Insurance Information: (Office only)

Secondary Insurance Company: _____ Ins Claim Adj / Verifier: _____
Phone: _____ Fax: _____ Policy Effective Date: ___/___/___
Insured Name: _____ Date of Birth: ___/___/___ M or F
ID or Claim #: _____ Group Name: _____ Group #: _____
Deductible: Single \$ _____ Met \$ _____ Family \$ _____ Met \$ _____
OOP: Single \$ _____ Met \$ _____ Family \$ _____ Met \$ _____
Deductible included in the OOP amount: YES or NO Visits Allowed _____
Patient Percentage: _____ OR Copay: _____