

Patient Registration Form



First Name _____ MI _____ Last Name _____

Date of Birth _____ Social Security # _____ Gender: M F

Patient Address _____
Street City State Zip Code

Mailing Address same? Yes No If no, Mailing Address _____
Street City State Zip Code

Patient Employer: _____ / _____
Name Phone Street City State Zip Code

Email Address: _____ Interpreter Needed? Yes No Language: _____

Emergency Contact: _____ Relationship: _____ (Spouse, parent, child, etc.)
Name Phone(s)

Phone(s):

OK to Call

Home: _____ Marital Status Married Single Separated Widowed Unknown Divorced

Work: _____ Employment Status Full Part Self Military None Retired

Cell: _____ Student Status Full None Part School Name: _____
ATC Notified Yes No

Medicare Patients

Have you received outpatient physical, speech or occupational therapy in the past year? Yes No Where: _____

Are you receiving home health services? Yes No Where: _____

Guarantor

Same as Patient

Name: _____ DOB: _____ Rel to patient: _____
(parent, spouse, etc.)

Gender: M F SSN: _____ Phone: _____ Home Work Cell
Address: _____
Street City State Zip Code

Employer: _____ / _____
Name Phone Street City State Zip Code

Primary Insurance:

Insured Name: _____ DOB: _____ Rel to patient: _____
 Same as Patient Same as Guarantor (parent, spouse, etc.)

Gender: M F SSN: _____ Phone: _____ Home Work Cell
Address: _____
Street City State Zip Code

Employer: _____ / _____
Name Phone Street City State Zip Code

Secondary Insurance:

Insured Name: _____ DOB: _____ Rel to patient: _____
 Same as Patient Same as Guarantor (parent, spouse, etc.)

Gender: M F SSN: _____ Phone: _____ Home Work Cell
Address: _____
Street City State Zip Code

Employer: _____ / _____
Name Phone Street City State Zip Code

Other applicable insurances? _____ Injury related to: Employment Auto Abuse Other _____
State: _____

If WC – Are you currently working? Yes No If no, date last worked: _____ If Attorney: _____

Medical Information

Referring Physician: _____ Date of Next Visit: _____
First Last

Onset Date of Injury/Issue: _____ Have you had therapy for this injury area before? Yes No
Where: _____

How did you hear about us? _____ (physician, patient, employee, newspaper, FB, etc.)

My signature below confirms the above information is accurate

Patient/Guarantor: _____ Date: _____