PATIENT REGISTRATION FORM

Today's Date: _____ Name (listed on insurance card): _____

Preferred Name (Nickname): _____ Date of Birth: _____/_____/_____ SSN: _____-_____-_____

Address: _____

Home Phone: _____ Alt. Phone: _____ Email: _____

Student: Yes / No School: _____ Marital Status: _____ Spouse's Name (Parent if minor): _____

Employer: _____ Employer Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Person responsible for bill: _____

Was illness/injury work related? Yes / No Was illness/injury the result of an auto accident? Yes / No

Primary Insurance: _____ Secondary Insurance: _____ Tertiary Insurance: _____

Medicaid Patients – Have you completed your EPSDT screening with your Primary Care Physician? Yes / No

Medicare Patients – Have you received PHYSICAL/OCCUPATIONAL therapy this calendar year? Yes / No

Tricare Patients – Do you have Prime or Standard? _____ Policy Holder's SSN: _____-_____-_____

Tricare Prime Patients – List your authorization number: _____

Auto Accident Patients – Claim #: _____ Adjuster: _____ Phone: _____

Workman's Comp Patients – Claim #: _____ Case Mgr/Adjuster: _____ Phone: _____

Describe the reason for your visit: _____

Onset Date (injury, accident, surgery date or recent date symptoms began): _____

How did the problem occur? _____

Was the injury a CONTACT or NON-CONTACT injury? If CONTACT, what did you come in contact with? _____

Where were you when problem occurred? _____

Have you seen a Healthcare Professional for this problem? Yes / No If yes, who? _____

Referring Physician: _____ Next appointment with Referring Physician: _____

Primary Care Physician: _____ Next appointment with Primary Care Physician: _____

Have you had any of the following in regards to this problem? Surgery ▪ Cat Scan ▪ MRI ▪ Bone Scan ▪ X-Rays

If you circled one of the procedures above, please list provider and date performed: _____

Have you had 2 or more falls in the past year? Yes / No

Have you had a fall in the past year that resulted in injury? Yes / No