

PATIENT REGISTRATION

ADMIT DATE:	Facility Name/Facility #:	INTAKE COMPLETED BY:
ACCOUNT #:		
FIRST NAME: *	MI: LAST NAME: *	MARITAL STATUS: M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> U <input type="checkbox"/>
STREET ADDRESS: *	ZIP CODE: *	CITY: *
HOME PHONE: *	WORK PHONE:	CELL PHONE:
SOCIAL SECURITY #:	CO-PAYMENT AMOUNT:	EMAIL ADDRESS:
HOW MANY INSURANCE PLANS?:	SEX:	DATE OF BIRTH: *
SURGERY DATE: BODY PART:*	REFERRING DOCTOR: *	UPIN # _____ NPI # _____ NOTE: Both Required

PRIMARY INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: *

*Have you received physical therapy, occupational therapy, or chiropractic services in the past year? Yes No

How Many Visits _____

INS. COMPANY ADDRESS:	CITY: STATE:	ZIP: PHONE #:*
NAME OF INSURANCE POLICY HOLDER: *	INSURED'S SOCIAL SECURITY #	INSURED'S DATE OF BIRTH:
INSURED'S POLICY #: *	WORKERS COMP CASE MANAGER NAME:	PHONE #:
INSURED'S EMPLOYER: *	EMPLOYER ADDRESS:	EMPLOYER STATE: ZIP:
PATIENT INSURANCE GROUP #:	PATIENT INSURANCE POLICY #:	
RELATIONSHIP TO INSURED:	EFFECTIVE DATE OF INSURANCE PLAN:	IF AUTO OR WORK RELATED, DATE OF INJURY: STATE:

SECONDARY INSURANCE INFORMATION

SECONDARY INSURANCE COMPANY NAME:

INS. COMPANY ADDRESS:	STATE: ZIP:	PHONE #:
NAME OF INSURANCE POLICY HOLDER:	INSURED'S SOCIAL SECURITY #:	INSURED'S POLICY #:
	INSURED'S DATE OF BIRTH:	
PATIENT INSURANCE GROUP #:	PATIENT INSURANCE POLICY #:	RELATIONSHIP TO INSURED:

Do you have an attorney for this injury? Yes No

Have you had home health care prior to physical therapy? Yes No If yes date discharged _____

RX DATE: * _____ FREQ & DURATION _____ THERAPIST * _____

PATIENT SIGNATURE _____ DATE _____