



**PATIENT REGISTRATION**

Date: \_\_\_\_\_

\*Last Name: \_\_\_\_\_ \*First Name \_\_\_\_\_ MI: \_\_\_\_\_ \*M/F Marital Status \_\_\_\_\_

Street Address: \_\_\_\_\_ Mailing Address \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

\*Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ \

Primary Number ~ Home / Cell \*Personal E-Mail: \_\_\_\_\_

\*Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ or Drivers License # \_\_\_\_\_

\*Referring Physician \_\_\_\_\_ Return to Dr date \_\_\_\_/\_\_\_\_/\_\_\_\_ \*Assigned PT \_\_\_\_\_

\*ICD-9 Diagnosis / Medical Reason for coming \_\_\_\_\_ \*Related cause \_\_\_\_\_

**\*PRIMARY INSURANCE INFORMATON**

Who is the Insured? Self ( ) Spouse ( ) Parent ( ) Other ( )

\*Insurance Company Name : \_\_\_\_\_ \*Ins Ph # \_\_\_\_\_

\*Subscriber's Full Name \_\_\_\_\_ \*Subscriber's DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

\*Subscriber's SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_ \*Ins ID # \_\_\_\_\_ \*Group # \_\_\_\_\_

Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Co-pay Amt. \_\_\_\_\_ or % of Co-Insurance \_\_\_\_\_ Deductible \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Ph Number \_\_\_\_\_

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**EMPLOYER INFORMATION**

Employer Name \_\_\_\_\_ Job Title \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**SECONDARY INSURANCE INFORMATON**

Who is the Insured? Self ( ) Spouse ( ) Parent ( ) Other ( )

Insurance Company Name : \_\_\_\_\_ Ins Ph # \_\_\_\_\_

Subscriber's Full Name \_\_\_\_\_ Subscriber's DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Subscriber's SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Ins ID # \_\_\_\_\_ Group # \_\_\_\_\_

Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Co-pay Amt. \_\_\_\_\_ or % of Co-Insurance \_\_\_\_\_ Deductible \_\_\_\_\_

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\*\*\*Make sure patient is not in home health when they come for outpatient PT – they will be liable for the visit \*\*\*

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