# Patient Registration

## Patient Information

First Name: ______________________________ Last Name: ________________________________Middle Initial: ______
Address: ___________________________________________________________________________________________
City, State, Zip: _____________________________________________________________________________________
Home Phone: _____________________ Cell Phone: ________________________ Work Phone: _____________________
Birth Date: ________________________ Social Security Number: _________________________________
Gender: Male ◯ Female ◯ Employment Status: Employed ◯ Student: Full Time ◯ Part Time ◯
Marital Status: Married ◯ Single ◯ Other ◯

## Emergency Contact

Name: ____________________________________________ Relationship: _____________________________________
Phone Number: __________________________________

## Responsible Party

Name: __________________________________________ Relationship: _______________________________________
Address: ____________________________________________________________________________________________
Phone Number: _______________________________

## Referral Information

Referring Physician: _________________________________ Primary Doctor: ___________________________________
Attorney: ___________________________________________ Case Manager: ___________________________________
Employer: __________________________________________ Occupation: ______________________________________

## Primary Insurance

Insurance: _____________________________________
Name of Insured: ________________________________
Relationship to Insured: ___________________________
Name / Address of Insured: (*If other than patient*)
_______________________________________
_______________________________________
_______________________________________

Insured Birthday: ________________________________
Group Number ___________________________________
Policy Number: _________________________________

Co-pay: _____________

## Secondary Insurance

Insurance: _____________________________________
Name of Insured: ________________________________
Relationship to Insured: ___________________________
Name / Address of Insured: (*If other than patient*)
_______________________________________
_______________________________________
_______________________________________

Insured Birthday: ________________________________
Group Number ___________________________________
Policy Number: _________________________________

Co-pay: _____________

## Injury Information

Injury Area: ________________________________ Related To: Employment ◯ Auto◯ /State _______ Other ◯
Unable to Work: From ______________To: _______________ Hospitalized: From ________________To: ________________

Patient Signature: ______________________________________________________________ Date: ____________________
Responsible Party Signature: _____________________________________________________ Date: ____________________
Relationship: ____________________________________________

**For Office Use Only**

Account Number: ____________________________

Account Type: ______________________________ First Visit Date: __________________ Injured Date: ___________________

Assigned Facility: _________________________________ Assigned Therapist: _______________________________________

Discipline: _________________________ PTPN: Yes ○ No ○ Referring Doctor NPI: _______________________________

Authorized Visits: _______ Auth Exp. Date: ____________________ Max. Units Per Day: ______ Charge Per Day: __________

Co-Insurance: _______________ Deductible: ______________ Charge Limit: _______________

Authorization Number: ______________________________________________________

Default Diagnosis Code: 1. ____________________________________ 2. ________________________________________

3. ____________________________________ 4. ________________________________________