

Registration Form

Patient Information

Patient Name _____
 Address _____
 Phone _____ Email _____
 Patient DOB _____ Patient SS # _____
 Physician _____ Phone _____
 Emergency Contact _____ Phone _____
 Race (*check one*) Caucasian African American Asian Pacific Islander American Indiana
 Other _____
 Ethnicity (*check one*) Non-Hispanic Hispanic

Accident Information

Injury _____ Date of Injury _____
 Cause of Injury _____

 Diagnosis Codes _____

Physical Therapy

Date of Initial Evaluation _____ Time Scheduled _____
 Previous Therapy (past year) _____
 Diagnosis Codes _____

Primary Insurance

Insurance Company _____ Phone _____
 Policy Holder _____ Employer _____
 Member ID # _____ Group # _____ Member SS # _____
 Member DOB _____ Relationship to Patient _____
 Authorization # _____ Date _____
 Number of Days/Visits Approved _____ No Authorization Required
 Deductible _____ Met Co-insurance/Copay _____ Met
 Benefits/Comments _____

Secondary Insurance

Insurance Company _____ Phone _____
 Policy Holder _____ Employer _____
 Member ID # _____ Group # _____ Member SS # _____
 Member DOB _____ Relationship to Patient _____
 Authorization # _____ Date _____
 Number of Days/Visits Approved _____ No Authorization Required
 Benefits/Comments _____
