plan physical therapy
injury . recovery . connected

Patient Registration

Patient Name: First_______________ MI___ Last__________________ DOB: ____________ SS#:___________________

Address: ____ City: ____________ State: ___ Zip: __________

❑ Male ❑ Female ❑ Single ❑ Married ❑ Other Phone: _________________________________

Employer: ____ Work Phone: ____________________________

E-mail Address: _______________________________________ Cell Phone: _____________________________

How Did You Hear About Plan Physical Therapy: ____

Referring Doctor: ____ Phone: __________ Fax: ___________________

Primary Care Physician: _________________________________ Phone: __________ Fax: ___________________

Area of Treatment: ____

Do You Have:

❑ Injury: _________/_________/________

❑ Surgery: ________/________/________

❑ Accident: _______/________/________

Is This Related To:

Employment? ❑ Yes ❑ No

Auto Accident? ❑ Yes ❑ No

Other Accident? ❑ Yes ❑ No

Primary Insurance: ____ Contact Phone #: ________________________

Policy Holder: ❑Me ❑Family: ____________________________ Date of Birth: ___________________________

Insured's Address: _____________________________________ City: ___________ State: ___ Zip: ___________

Group # (or Name): ____________________________________ ID# (or Claim#): __________________________

Adjuster or Case Worker: _______________________________ Contact Phone #: ________________________

Secondary Insurance: ____ Contact Phone #: ________________________

Policy Holder: ○Me ○Family: ____________________________ Date of Birth: ____________________________

Insured's Address: _____________________________________ City: ____________ State: __ Zip: ___________

Group # (or Name): ____________________________________ ID# (or Claim#): __________________________

Adjuster or Case Worker: _______________________________ Phone #: ________________________________

Auto/Worker's Comp Insurance: ________________________________ Case/Claim #: ____________________________

Adjuster/Caseworker's Name:_____________________________ Phone #: ________________________________

Attorney: ____ Phone #: ________________________________