

Name:	Today's Date:
Address:	PCP Doctor:
City: State:	Town:
Zip Code:	Phone#:
Phone #:	Referring Doctor:
Cell Phone #:	Town:
Alternate or Work # :	Phone#:
Date Of Birth: Age:	Employer:
SS Number:	Occupation:
Sex: Male / Female	Emergency Contact:
Race:	Relationship:
Height:	Phone #:
Weight:	Are you under 18 years old? Y / N
Marital Status: (please circle) M S D W	If yes please print Parent or Legal Guardian:
Preferred Pharmacy:	Name:
Pharmacy Phone #:	Phone #:
	Cell #:

Insurance Information

Primary Insurance Company:

ID #:	Group ID #:
Policy Holder:	Relationship:
Date of Birth:	Employer:
SS Number:	Co pay Amount:

Secondary Insurance Company:

ID #:	Group ID #:
Policy Holder:	Relationship:
Date of Birth:	Employer:
SS Number:	

Insurance Card and Photo ID required at Registration

****Co-Pay and/or Payment is Expected at the Time of Service****

The Reason for Your Appointment today:

Are you currently or have you in the past participated in a physical therapy program Y / N

If Yes Where? _____ When? _____

****We Do Not Accept Letters of Protection from Attorneys.****

Are you currently represented by an Attorney regarding your visit today? Y / N

Attorney: _____ Fax# _____

Address: _____ Case / File#: _____

_____ Phone: _____

Complete the Following if This is Workers Compensation

Body Part Injured (Neck or Back):	
Date of Injury:	Are you Currently out of Work?: Y / N
Employer:	Last Date Worked:
Address:	Employer Phone#:
City: State:	Employer Fax #:
Zip Code:	
Workers Comp Insurance Company Name:	
Address:	Workers Comp Insurance Phone:
City: State:	Workers Comp Insurance Fax#:
Zip Code:	Claim #:
Claim Adjuster:	File #:
Claim Adjuster Phone #	

Complete the Following if This is a Motor Vehicle Accident

Body Part Injured (Neck or Back):	
Date of Accident:	State Where Accident Occurred:
Your Auto Insurance Company:	Policy #:
Address:	Contact Person:
City: State:	Phone:
Zip Code:	Fax #:
Claim Adjuster:	
Claim Adjuster Phone #:	Claim #
Claim Adjuster Fax#:	File #:

Radiology Test History

Please list any MRI, CT Scan, and/or X-ray exams you have had, including the date and location:

****Please bring all films and reports with you to your appointment****

By signing below, I attest that the above information is correct. If I have provided invalid information and if my charges are not covered by my insurance company, I acknowledge that I am responsible for paying them in full.

Patient Signature _____ Dated _____

By initialing and dating below, I am confirming all information on this form remains the same and is accurate

Initial _____ Dated _____