PHYSICAL THERAPY & SPORTS MEDICINE CENTERS

PT for life A PTSMC affiliate

Patient Registration

NAME		HOME PHONE
ADDRESS		CELL PHONE
DATE OF BIRTH	GENDER M / F	WORK PHONE
EMAIL	REFERRING MD	
INJURY DESCRIPTION		
EMERGENCY CONTACT	RELATIONSHIP	PHONE (C / W / H)

HOW DID YOU HEAR ABOUT US?

☐ Doctor ☐ Friend/Family ☐ Web Search ☐ Advertisement ☐ Social Media ☐ Community Development Coordinator

☐ Community Event _____ ☐ Athletic Trainer – School: _____

If you had an accident, please fill out this section:

Please circle: WORKERS COMP AUTO INJURY SCHOOL INJURY			DATE OF ACCIDENT/INJURY:
STATE ACCIDENT OCCURRED	MED PAY COV Y / N	MED PAY EXHAUSTED Y / N	SCHOOL INS Y / N
EMPLOYER / SCHOOL AT TIME OF INJURY			
EMPLOYER / SCHOOL ADDRESS			
SOCIAL SECURITY # (IF WORKER'S COMP) _____-_____-_____			
ATTORNEY NAME			
ATTORNEY ADDRESS AND PHONE			

Insurance Information- Please give your insurance cards to the front desk staff for copying.

PRIMARY INSURANCE	ID/CLAIM #	GROUP/POLICY #
INSURED'S NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH
SECONDARY INSURANCE	ID/CLAIM #	GROUP/POLICY #
INSURED'S NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH
TERTIARY INSURANCE	ID/CLAIM #	GROUP/POLICY #
INSURED'S NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH

I HAVE VERIFIED THE ABOVE INFORMATION TO BE TRUE AND COMPLETE.

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____