PHYSICAL THERAPY PLUS

NEW PATIENT REGISTRATION FORM

Patient Information

Legal Name: ____ Age: ___________ DOB: _________________
SSN: ____ Male _____ Female _____
Address: ____ Email Address: ______________________________
City: ________________________ State: ____ Zip: ___________ Work Phone: _________________________________
Home phone: ___________________________ __ Cell Phone: _______________________________
Employed? ____ Yes ____ No Retired ____Y ____N
Employer's Name _________________________________ _____ Married ____Y ____N
Employer's Phone # _______________________________ _____ Student ____Y ____N
Referring Physician: ______________________________ Location of Office __________________________
Primary Physician: ______________________________ Location of Office __________________________

Were you injured due to: _____ Auto Accident ____Work _____ Other Date of Injury: ______________
Have you had physical therapy before? ____Y ____N When? _____________ For how long? ______
Are you currently receiving any home health services? ____Y ____N

Responsible Party Information (*Must complete if client is a minor*)

Name: ____________________________________ SSN: _______________________________ DOB: ____________
Address: __________________________________ City: _______________________ State: _____ Zip: _____________
Home phone: _________________________ Cell: ____________________ Work: _________________

Emergency Contact: ___________________________ Relationship ______________ Phone: ________________

Primary Insurance

Name of Insured: _____________________________________ DOB of Insured: ___________________________
Insured's Employer: ___________________________________ SSN of Insured: ___________________________
Address of Insured (if different than patient): ____
Name of Insurance Company: _______________________________ Insurance ID # ___________________________
Patient's Relationship to Insured (please check one): Self ____ Spouse ____ Child ____ Other ____

Secondary Insurance

Name of Insured: _____________________________________ DOB of Insured: ___________________________
Insured's Employer: ___________________________________ SSN of Insured: ___________________________
Address of Insured (if different than patient): ____
Name of Insurance Company: _______________________________ Insurance ID # ___________________________
Patient's Relationship to Insured (please check one): Self ____ Spouse ____ Child ____ Other ____

I do not have insurance ______ I am interested in a customized payment plan (check one): ______Y ______N

Check All That Apply:

_____ PT Plus may send notifications via text message to the above cell phone number.
_____ PT Plus may leave messages at the above phone numbers.
_____ PT Plus may contact me at the email address above.

____ ___________________
(Patient or Guardian Signature) ***(Date)***