Family Physical Therapy

Patient Registration

Personal Information	***Please complete all areas.***	
Social Security Number:	Date of Birth:	
Last Name:	First Name:	MI:
Address:	Email Address:	
City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:
Sex: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Other:	

Patient's Employer Information			**Insured's Employer Information** **(Leave blank if same as patient)**		
Employer Name:			Employer Name:		
Employer Address:			Employer Address:		
City:	State:	Zip:	City:	State:	Zip:

Referring Physician Information	
Diagnosis:	Visit Frequency/ Duration:
Referring Physician:	
Insurance Coverage: **Insurance card must be presented at time of service.**	

Emergency Contact Information		
Last Name:	First Name:	MI:
Relationship: ☐ Spouse ☐ Parent ☐ Friend ☐ Child ☐ Other:		
Home Phone:	Work Phone:	Cell Phone:

Other Information	
Date of Injury (Onset):	Accident: ☐ No Accident ☐ Auto ☐ Work ☐ Other:
Description of Injury:	If Auto Accident, list State where accident occurred:

Patient Certification and Signature	
I certify that all of the information provided herein is true and correct.	
Patient/Guardian Signature:	Date: