Patient Registration Form

First Name _____ MI ___ Last Name _____ Title _____

Date of Birth _____ Social Security # _____ Gender ☐ Male ☐ Female

Mailing Address _____

_____

Physical Address _____

_____

_____ Driver's Lic # _____

		OK To Call	Best Time To Call
Home Phone	_____	☐	_____
Work Phone	_____	☐	_____
Cell Phone	_____	☐	_____

Marital Status
- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Unknown

Employment Status
- ☐ Full-Time
- ☐ Part-Time
- ☐ Self Employed
- ☐ Active Duty
- ☐ Disabled
- ☐ Retired

Student Status
- ☐ None
- ☐ Full time
- ☐ Part time

Email Address _____ Interpretor Required? ☐ Language _____

Patient Employer	_____	Spouses Employer	_____
Address	_____	Address	_____
	_____		_____
Phone	_____	Phone	_____
Occupation	_____	Occupation	_____

How did you hear about us?

- ☐ Physician
- ☐ Employer
- ☐ Case Manager
- ☐ Former Patient
- ☐ Adjustor
- ☐ School
- ☐ Hospital
- ☐ Cross Referral
- ☐ Friend - Word of Mouth
- ☐ Attorney
- ☐ Self
- ☐ Screens - Open Houses
- ☐ Marketing Ad - Print
- ☐ Marketing Ad - TV
- ☐ Marketing Ad - Billboard
- ☐ Marketing Ad - Direct Mail - Email

Specify: _____

Attorney Name _____ **Phone** _____

Address _____

_____

Emergency Contact _____ **Phone** _____

Address _____

_____

Prescribing MD _____ **Phone** _____

Do you have a written prescription? ☐ **Yes** ☐ **No** **Next MD Visit** _____

Body Part / Region _____ **Date of Injury** _____

Was this injury the result of an accident? ☐ **Work** ☐ **Auto** ☐ **Other** ☐ **None**

Do you wish to receive social services? ☐ **Yes** ☐ **No**

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I hereby authorize the release of any and all information to my insurance company or other appropriate party, as required, pertaining to treatment rendered to me by Independent Physical Therapy. Further, I authorize Independent Physical Therapy to obtain needed information from my physician, employer or insurance company.

CONSENT TO TREATMENT & FINANCIAL RESPONSIBILITY

I hereby consent to the treatment as prescribed by my physician and provided by Independent Physical Therapy, its employees, or representative. I understand that I am ultimately responsible for charges related to my treatment. All accounts are due and payable upon receipt of the bill.

NOTICE OF INFORMATION PRACTICES

I acknowledge that I have been shown the posted Notice of Information Practices by Independent Physical Therapy

_____ _____

Signature of Patient **Date**