Optimum Recovery RehaB
PHYSICAL THERAPY

PATIENT REGISTRATION FORM

Date:_____

Last Name:_____First Name:_____MI:_____

Social Security #:_____Date of Birth:_____Sex: M F
Marital Status: Single_____Married_____Divorced_____Widowed____Civil Union_____
Address:_____City:_____State:_____Zip:_____

_____
Phone #home:_____Cell:_____May we leave messages at the phone nos. given? __Yes __No
Emergency Contact:_____Relationship:_____Phone #:_____
Email:_____Referred by:_____
Employer:_____Address:_____
_____ _____
Employer Phone #:_____
Primary Care Physician:_____Phone #:_____
Referring Doctor:_____
Problem that brought you to this office:_____

Was this caused by: ___an injury ___Fall ___Accident ___Car Accident ___Work related injury
How long have you had this condition?_____
Medications prescribed to you for this condition:_____
Other medications that you are currently taking:_____
Other current medical problems:_____
Past Surgeries:_____
Allergies to medications or substances:_____
Additional information or health concerns:_____
_____

Insurance Information

Person Responsible for Account (Policy Holder)
Last Name:_____First Name:_____MI:_____
Relationship to patient: Self ___ Spouse___ Parent___ Other_____
Social Security #:_____Date of birth:_____Sex: M F
Address:_____
Street City State Zip

Employer Name:_____
Address:_____Business Phone #:_____
_____

Type of Insurance:
Commercial___ Workers Comp___ Auto No Fault___ Medicare___
Insurance Name:_____Subscriber ID #:_____
Group no.:_____Policy no.:_____
Carrier Address:_____
Case no./Claim no. (if applicable):_____

Other Insurance Name:_____Subscriber ID no.:_____
Group no.:_____Policy no.:_____

If Worker's Compensation/Auto No-Fault:
Date of Injury/Accident:_____Location:_____
Case Manager (if applicable):_____Phone no.:_____
Attorney:_____Firm Name:_____
Address:_____City:_____State:_____Zip:_____
_____
Phone no.:_____