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# Adult New Patient REGISTRATION FORM

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| Today’s date: | PCP:  |
| PATIENT INFORMATION |
| **Patient’s name:** | Marital status  |
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| Is this your legal name? | If not, what is your legal name? | Birth date: | Age: | Sex: |
|  |  |  |  |  |
| Street address: | Social Security no.: | Home phone no.: |
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| P.O. box: | City: | State: | ZIP Code: |
|  |  |  |  |
| Occupation: | Employer: | Employer phone no.: |
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| INSURANCE INFORMATION |
| (Please give your insurance card to the receptionist.) |
| Person responsible for bill: | Birth date: | Address (if different): | Home phone no.: |
|  |  |  |  |
| Occupation: | Employer: | Employer address: | Employer phone no.: |
|  |  |  |  |
| Insurance: |  |  |
| Subscriber’s name: | Subscriber’s Birth Date.: | Subscriber ID | Group no.: |
|  |  |  |  |
| Patient’s relationship to subscriber: |  |
| Name of secondary insurance (if applicable): | Subscriber’s name: | Subscriber ID: | Group no.: |
|  |  |  |  |
| Patient’s relationship to subscriber: | Choose an item. |
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| IN CASE OF EMERGENCY |
| Name of local friend or relative (not living at same address): | Relationship to patient: | Phone No.: |
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| Medical History |
| Description of Problem: |  |
| When did this problem begin? |  |
| Is this problem related to an accident or injury?  |  |
| Have you been treated by a professional for this problem in the past? |  |
| Have you had and surgeries? If yes, please list all surgeries  |  |
| Have you received Physical, Occupational, Chiropractic or Speech therapy before? If yes, when and where? |  |
| Are you currently receiving home treatment? |  |
| Please Check any tests you have had related to this problem: |
| MRI |  | XRAY |  | CT Scan |  | OTHER: |  |
| Please List any medications you are currently taking: |
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| Consent to TreatI consent to receive rehabilitation therapy treatment and any supplementary services that are deemed medically necessary or appropriate by my therapist and/or treating physician. However, I understand that the practice of rehabilitation therapy is not an exact discipline and I acknowledge that no guarantees have been made to me regarding treatment and/or the treatment results from the rehabilitation therapy. |
| Patient/Guardian Signature |  | **Date:** |  |
| Patient/Guardian Name (Print) |  |
| Financial Responsibility I agree to pay my rehabilitation therapy provider all amounts that are due and owing for services rendered by Provider which are not otherwise paid for by Medicare, a third party insurance plan, a third party payor, or other payor source on my behalf. In the event that my account is referred to a collection agency or an attorney, I further agree to pay all reasonable costs incurred to collect any amounts that are due and owing for services rendered by Provider including, without limitation, reasonable attorney’s fees. |
| Patient/Guardian Signature |  | **Date:** |  |
| Patient/Guardian Name (Print) |  |