# 

# Adult New Patient REGISTRATION FORM

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Today’s date: | | | | | | | | | | | | | | | | PCP: | | | | | | | |
| PATIENT INFORMATION | | | | | | | | | | | | | | | | | | | | | | | |
| **Patient’s name:** | | | | | | | | | | | | | | | Marital status | | | | | | | | |
|  | | | | | | | | | | | | | | |  | | | | | | | | |
| Is this your legal name? | | If not, what is your legal name? | | | | | | | | | | Birth date: | | | | | | | | Age: | | Sex: | |
|  | |  | | | | | | | | | |  | | | | | | | |  | |  | |
| Street address: | | | | | | | | | | | | | | Social Security no.: | | | | | | Home phone no.: | | | |
|  | | | | | | | | | | | | | |  | | | | | |  | | | |
| 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 Treat  I 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) | | |  | | | | | | | |