THE
Physical Therapy
CENTER
We Listen ■ We Care ■ We Get Results

Patient Registration

Today's Date ____________________

Personal Information

______________________ ______________________ ________ ☐ Male ☐ Female
Last Name First Name Age

____
Street Address City State Zip

(______)__________________(______) ____________________________
Home Phone Cellular Email Address (Important)

Social Security # ____________________ Date of Birth ______/______/______ ☐ Single ☐ Married

____________________(______) ____________________
Emergency Contact Person Phone #

____________________________________(______)____________
Occupation Employer Name Phone #

Work Status: ☐ Currently Employed ☐ Retired ☐ Disabled (___Total or ___Temporary) ☐ Student (___P/T ___F/T)

My condition is related to: ☐ Work ☐ Auto Accident (State __________) ☐ Other ____________________

Referral Information

How did you hear about us?

- ☐ Doctor's Referral
  Name ____________________
- ☐ Friend / Family Member
  Name ____________________
- ☐ Nurse Case Manager
- ☐ Phone Book
- ☐ Mailer/Postcard
- ☐ TV Commercial
- ☐ Radio
- ☐ Newspaper
- ☐ Open House / Event
- ☐ Other ____________________

Insurance Cardholder's Information

____
Last Name First M.I.

____
Date of Birth Relationship to Patient

____
Street Address City State Zip

____
Cardholder's Employer Name

____
Employer's Address City State Zip

(____) ______________ (_____) ______________
Cardholder's Home Phone Cardholder's Work Phone

____
Cardholder's Social Security #

Consent for Care & Treatment

I, the undersigned, do hereby agree and give consent for The Physical Therapy Center to furnish medical care and treatment that is considered necessary and proper in diagnosing or treating my (his/her) physical and mental condition.

____
Patient/Guardian Signature

Office Use Only
Acct. #:____________________
Therapist Name:____________________
Rx Date:____________________
Dr. Name: ____________________