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: ____________________________