



PATIENT REGISTRATION

PATIENT INFORMATION

PATIENT NAME (Last, First, Middle Initial)			
ADDRESS		SOCIAL SECURITY NUMBER	DATE OF BIRTH
CITY	STATE	ZIP	EMAIL ADDRESS
HOME PHONE NUMBER	WORK PHONE NUMBER	CELL PHONE NUMBER	(Circle One) Female Male

***If you have received HELP in the HOME (bathing, aide help, therapy, nurse visit) in the past three months, please **stop** here, and speak to our receptionist before completing the rest of the patient registration.

For Office Use: (Receptionist - For Medicare patients, call (866) 211-5708 and initial if the patient is already receiving care.) _____
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How did you hear about us? Check One: Doctor _____ Advertisement/Radio _____ Internet _____
 Friend/Relative (who?) _____ Employee (who?) _____ Other _____

WHO IS FINANCIALLY RESPONSIBLE FOR TREATMENT?

Myself My Spouse My Parent(s) (Other) or Responsible Party _____

Who is your Primary Care Physician? _____

Who is your Specialty Physician? _____ Other Physician: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:	SECONDARY INSURANCE COMPANY:
POLICY NUMBER:	POLICY NUMBER:

POLICY HOLDER'S INFORMATION

NAME	RELATIONSHIP TO PATIENT	SOCIAL SECURITY NUMBER
ADDRESS (if different from above)		DATE OF BIRTH
CITY	STATE	ZIP
		HOME PHONE (if different from above)
IS THE POLICY HOLDER CURRENTLY EMPLOYED BY THE EMPLOYER PROVIDING INSURANCE? YES NO N/A ARE		
YOU OR THE PATIENT ON MEDICAL LEAVE? YES NO N/A		
EMPLOYER NAME:		EMPLOYER PHONE NUMBER:

EMERGENCY CONTACT (NOT living with you)

NAME (Last, First, Middle Initial)	RELATIONSHIP TO PATIENT
ADDRESS	CITY STATE ZIP
PHONE #	
Workers' Comp On-the-job Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of injury:
Employer Name, Contact Person & Phone Number:	