PTA Physical Therapy Associates, Inc.

# PATIENT REGISTRATION

## PATIENT INFORMATION – Please Print

| | |
|---|---|
| **Patient Name (Last, First, MI):** | **DOB:** **AGE:** |
| **Address:** | **SSN:** |
| **City, State, Zip:** | **Gender:** ☐ Male ☐ Female |
| **Home Phone:** **Cell Phone:** | |
| **E-mail Address:** | **Marital Status:** ☐ Married ☐ Single ☐ Divorced ☐ Widowed |
| **Authorized Communication Method (check all that apply):** ☐ Mail ☐ Home Phone ☐ Cell Phone ☐ E-mail | |
| **Employer Name:** | **Work Phone:** |
| **Employer Address:** | **May we contact you at work?** ☐ Yes ☐ No |
| **Employer City, State, Zip:** | |
| **Spouse Name:** | **Spouse SSN:** |

## GUARDIAN INFORMATION

| | |
|---|---|
| **Is the patient under 18 or do they require a legal guardian?** ☐ Yes ☐ No *(If No, skip to Emergency Contact Info)* | |
| **Guardian Name:** | **DOB:** |
| **Guardian SSN:** | **Relationship to Patient:** |

## EMERGENCY CONTACT

| | |
|---|---|
| **Emergency Contact Name:** | |
| **Phone:** | **Relationship to Patient:** |

## INSURANCE INFORMATION

| | Primary | Secondary |
|---|---|---|
| **Insurance Company Name** | | |
| **I.D. / Policy Number** | | |
| **Group Number** | | |
| **Policyholder Name** | | |
| **Policyholder Address** (if different than patient) | | |
| **Policyholder Date of Birth** | | |
| **Policyholder Social Security #** | | |

| | |
|---|---|
| **Motor Vehicle Accident** ☐ Yes ☐ No | **Worker's Comp Injury** ☐ Yes ☐ No |
| **Date of Accident:** | **Date of Injury:** |
| **Claim Number:** | **Claim Number:** |
| **Adjustor's Name:** | **Adjustor's Name:** |
| **Adjustor's Phone:** | **Adjustor's Phone:** |

_____ _____ _____

**Patient Signature** **Parent/Guardian Signature** (Required if patient is under 18) **Date**

***HOW DID YOU FIND OUT ABOUT US?*** ☐ ***Friend*** ☐ ***Family*** ☐ ***Internet Search*** ☐ ***Other***

*Please give us the name of who referred you to our clinic -* _____