** Performance Physical Therapy & Rehabilitation Services**

 **PATIENT REGISTRATION FORM**

**TODAY’S DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOW DID YOU HEAR ABOUT US? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ S.S.N.** (for insurance verification**) \_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_**

 **HOME PHONE # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_WORK/OTHER#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **MAILING ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE\_\_\_\_\_\_\_ZIP\_\_\_\_\_\_\_\_\_**

 **DATE OF BIRTH\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ AGE\_\_\_\_\_\_\_ STATUS: S M W D SEX: M F**

 **EMAIL ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **EMERGENCY CONTACT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **REFERING DOCTOR\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NEXT DOCTORS APPOINTMENT\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_**

 **MAJOR COMPLAINT/DIAGNOSIS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF ONSET\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **IF YOUR ISSUE IS THE RESULT OF AN ACCIDENT PLEASE CHECK THE CORRECT TYPE:**

 **WORKERS COMP \_\_\_\_\_ AUTOMOBILE\_\_\_\_\_ OTHER \_\_\_\_\_ DATE OF ACCIDENT\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_**

 **EMPLOYER NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **CITY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE \_\_\_\_\_\_\_ ZIP \_\_\_\_\_\_\_\_ OCCUPATION \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **PRIMARY INSURANCE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SUBSCRIBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **SUBSCRIBER D.O.B. \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ RELATIONSHIP TO SUBSCRIBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **SECONDARY INSURANCE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SUBSCRIBER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **SUBSCRIBER D.O.B. \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ RELATIONSHIP TO SUBSCRIBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **WHO IS RESPONSIBLE FOR THIS BILL? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***I acknowledge that the above information is true and correct.***

 **SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Check us out on the web at **PerformancePT.com** and like our Facebook page**@PerformanceRehabandPT**