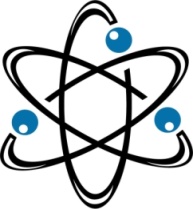
** Performance Physical Therapy & Rehabilitation Services**

**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**