# R.A.

PHYSICAL THERAPY & REHABILITATION

*Specialists who care, Results that matter, Helping you move through life!*

## PATIENT REGISTRATION

Today's Date: ________________

Patient Name: ____________________________________________ M ☐ F ☐

Date of Birth: ____________________ SS #____________________ Marital Status: S ☐ M ☐ D ☐ W ☐

Mailing Address: ______________________________ City: ______________ State: _____ Zip: _________

Phone #: ____________________ Cell #: ________________ Email: ____________________________

**How would you like us to Contact you? (Please Check all that Apply)☐ Email ☐ Phone ☐ Cell ☐Home ☐Work**

Employer: __________________________ Occupation: ______________ Work #: __________________

Date of Symptoms/Injury: __________ Date of Surgery: __________ Job related? Y ☐ N ☐ Auto accident? Y ☐ N ☐

Referring Physician: ____________________________ Primary Physician: ____________________________

Attorney Name (if applicable): ______________________________ Phone #: ________________________

Person responsible for bill if not above patient: ________________________________________________

Person to notify in case of emergency: __________________________ Phone #: ________________________

Relationship: ____________________________________________________________________________

Have you had Prior Physical Therapy? If Yes. When was the last Treatment_________ How many visits did you have ______

Are you currently being treated by a Chiropractor? Y ☐ N ☐ Are you currently being treated by an Acupuncturist? Y ☐ N ☐

**Medicare Patients: Have you received home health care in the past 60 days for physical therapy? Y ☐ N ☐**

**Where did you hear about our clinic**? ________________________________________________________

***Please Sign to verify that the information is correct and accurate:***

________________________________________ ________________________

Patient Signature or Guardian of Patient (if Minor) Date

If Guardian of Patient Please state relationship to Patient

________________________________________

**For Office Use:**
**Insurance WC PI Self Pay**