Sports Therapy and Rehabilitation Services
Patient Registration Form

General Information

Patient's Name: ____Today's Date: __________________

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed Guardian: ___________________________

Street Address: ____

City: ____State: ___________ Zip: ______________________

Social Security Number: _____________________________Date of Birth: _____/_____/_____ Age: ____________

Home Phone: __________________ Work Phone: ___________________ Cell Phone: _____________________

Email Address: ____

Employer: ______________________________________ Employer Phone Number: ______________________

Is this injury work related? ☐ Yes ☐ No

Referring Physician: _______________________________ Physician Phone Number: ______________________

How did you hear about us? ____

Insurance Information

Insurance Company: ____

ID Number: _______________________________ Group Number: _____________________________

Name of Insured: ____ Insured's Date of Birth: ____/__ __/____

Relationship to Patient: ____

Home Phone: ______________________________ Cell Phone: _______________________________

Name of Secondary Insurance (if applicable): ____

ID Number: _______________________________ Group Number: _____________________________

Are you currently receiving Home Health service? ☐ Yes ☐ No

If yes - Name of Agency?__________________________________Last Date of Service? ____/____/_____

Have you received PT, OT, or speech services since the first of this year? ☐ Yes ☐ No

Co-Insurance Payments: if you would like us to keep your credit card on file to process after services are rendered, please fill out information below. *This card will be charged for any balance that is 30 days past due or more.
Circle one: VISA MASTERCARD DISCOVER *Card Number: _______________________________

Expiration Date: _______________ Billing Address and Zip Code: ___________________________________

In Case of Emergency

Name of Local Friend/Relative: ____________________________ Relationship to Patient: __________________

Home Phone: __________________ Work Phone: ___________________ Cell Phone: ____________________

The above information is true to the best of my knowledge.

Patient/Guardian Signature: ____ Date: ____________________