

Arthritis & Sports Physical Therapy Patient Registration

| | |
|-------------------------------------|-----------------------|
| FIRST NAME: _____ | DOB: _____ |
| LAST NAME: _____ | |
| ADDRESS: _____ | SSN: _____ |
| CITY: _____ STATE: _____ ZIP: _____ | MARITAL STATUS: _____ |
| | SEX: _____ |
| INJURY AREA: _____ | |
| DATE OF INJURY: _____ | HOME PHONE: _____ |
| EMPLOYER: _____ | WORK PHONE: _____ |
| ADDRESS: _____ | CELL PHONE: _____ |
| CITY: _____ STATE: _____ ZIP: _____ | |

| | |
|--|------------|
| PRIMARY INSURANCE: _____ | |
| SUBSCRIBER NAME: _____ | DOB: _____ |
| RELATIONSHIP TO PATIENT: SELF SPOUSE CHILD OTHER | |
| SECONDARY INSURANCE: _____ | |
| SUBSCRIBER NAME: _____ | DOB: _____ |
| RELATIONSHIP TO PATIENT: SELF SPOUSE CHILD OTHER | |

| | |
|-----------------------|---------------------------------|
| WORKMAN'S COMP | |
| CLAIM# _____ | POINT OF CONTACT NAME: _____ |
| DATE OF INJURY _____ | POINT OF CONTACT #: _____ |
| CLAIM ADDRESS: _____ | WORKMAN'S COMP INSURANCE: _____ |
| | _____ |

| | |
|--------------------------|---------------|
| EMERGENCY CONTACT: _____ | PHONE#: _____ |
|--------------------------|---------------|

| | |
|---|--|
| Are you receiving or have you recently received home health services? Y N | |
| Are you receiving or have you recently received other therapy services? Y N | |

(please initial in boxes next to statements)

CONSENT FOR TREATMENT: I consent to rehabilitation and related services at Arthritis & Sports PT.

In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching and/or direct contact of a sensitive nature

TREATMENT OF MINORS: I, as parent/guardian of a minor receiving treatment here under, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.

LIABILITY: I know and agree that Arthritis & Sports PT is not responsible for loss or damage to personal valuables

FEE FOR SUPPLIES: Insurance will not cover certain supplies that are suggested by the therapists. This includes the electrodes used for the electrical stimulation. I understand, as a patient, that I am financially responsible for the cost of these items.

I certify that all of the information provided herein is true and correct

Patient/Guardian Signature _____

DATE: _____

Witness Signature: _____

DATE: _____