Amelia Physical Therapy Patient Registration Form

Where you are treated like family

Patient Name_____

Last First Middle initial Nickname

Street Address _____

City _____State _____ Zip _____

Phone (H) _____Phone Work _____Phone Cell _____

Email Reminder Yes or No **Or** Text Reminder Yes or No (***Please provide Carrier***)

Email Address_____ Cell Carrier _____

Date Of Birth _____Age_____ Male/Female Marital Status_____

Employer _____ Address _____

Insurance Plan _____How did you find out about this Practice?_____

Policy Holder's Name_____ Date of Birth_____

Address of Policy Holder _____Relation _____

Date of Injury ___/___/___ Referring Physician _____

Workers Comp? _____ Auto Accident? _____ State accident occurred _____

****IF YOU ARE COMING DIRECT ACCESS PLEASE FILLTHIS PORTION OUT**

DIRECT ACCESS yes/no Chief Complaint _____

Are you under a Doctor's care? _____ Doctor's name _____

*Note after 30 days, if the episode of care is to continue, the patient will require a script.

*I give consent to release all records to my Doctor of record (If identified above)
Sign:_____Date:_____

Emergency Contact:

Name_____Relationship_____

Phone (H)_____(W)_____(C)_____

Have you had any type of Therapy this year? _____

If mailing address is different than street address, please write the mailing address below:

_____

_____