PATIENT REGISTRATION FORM
ALLIED PHYSICAL THERAPY

_____ _____/_____/_____ M F
PATIENT NAME (Please Print) **BIRTHDATE** **SEX**

_____
MAILING ADDRESS **(or UMF Student Local Address)** **TOWN** **STATE** **ZIP**

_____
PHYSICAL ADDRESS **(or UMF Student HomeAddress)** **TOWN** **STATE** **ZIP**

_____ _____ YES NO TEXT cell or VOICE home
HOME PHONE (UMF Student **CELL PHONE** **MAY WE LEAVE** **Computerized Appointment**
(UMF Student Parents Phone) **MESSAGES?** **Reminders**

Full Part Not
Time Time Student Retired Employed _____ _____ YES NO
EMPLOYEMENT STATUS **YOUR EMPLOYER** **WORK PHONE** **MAY WE LEAVE**
MESSAGES?

_____ _____ _____ ___ _____ _____
IF MINOR, GUARANTOR **ADDRESS** **CITY** **STATE ZIP** **PHONE**

_____ _____
EMERGENCY CONTACT **RELATIONSHIP** **PHONE** **YOUR EMAIL**

INSURANCE INFORMATION

- ***PLEASE PROVIDE US WITH YOUR INSURANCE CARD(S) AT YOUR FIRST APPOINTMENT.***
- ***WE REQUIRE THAT ALL CO-PAYS BE PAID AT EACH VISIT.***
- ***IF THE PATIENT IS A MINOR, THE GUARDIAN WHO IS THE GUARANTOR MUST SIGN THIS FORM.***
- ***PLEASE CALL YOUR INSURANCE COMPANY IF YOU DO NOT UNDERSTAND YOUR PHYSICAL THERAPY BENEFITS.***

1) Yes No Yes No Self Spouse Dependent
DO YOU HAVE PRIMARY INSURACE? SECONDARY INSURANCE RELATIONSHIP TO INSURED

2) IS THIS A WORKERS COMPENSATION CASE? Yes No
PLEASE HAVE YOUR CASE NUMBER, DATE OF INJURY, NAME OF WORKERS COMPENSATION COMPANY,
CASE WORKER Name _____ Phone_____

3) IS THIS A MOTOR VEHICLE ACCIDENT? YES NO
PLEASE HAVE YOUR CASE NUMBER, DATE OF INJURY, NAME OF INSURNACE COMPANY,
CASE WORKER Name _____ Phone_____ext._____

Are you currently seeing anyone else for Physical, Occupational, or Speech Therapy? **Yes No**
Have you seen anyone else this calendar year for Physical, Occupational, or Speech Therapy? **Yes No**
Have you had any Home Health visits for Physical, Occupational, or Speech Therapy? **Yes No**
If yes, how many visits have you had?_____

I will notify Allied Physical Therapy of any changes on this form and on my Past medical History Form. _____

I attest that all the information I have given is truthful, to the best of my knowledge, and that I have read, understand and agree to the policies at Allied Physical Therapy._____

PATIENT SIGNATURE _____ **DATE**_____
(GUARDIAN IF MINOR)

PRINTED NAME _____