STAR REHABS (Physical Therapy)
120 W 7th St, Plainfield, NJ

PATIENT REGISTRATION AND INFORMATION

Please complete the appropriate information section below that applies to your visit with Star Rehabs Physical Therapy. This will help us determine the reason for your visit and the appropriate insurance provider to bill for services.

Patient Name: _____ DOB: _____

SSN: _____ — _____ — _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Cell Phone: (____) _____

Guardian (person financially responsible if patient is under 18 yrs. old)

Guardian's Name: _____ Relationship to patient: _____

Guardians address: _____

REASON FOR VISIT

1) WORK RELATED INJURY? (WORKERS' COMP)

DATE OF INJURY: _____

Place of Employment: _____

Contact Person: _____

Insurance Company: _____

Claim Number: _____

Legal Action Pending? _____

Your Lawyer's Name: _____

Lawyer's Contact Information: _____

2) MOTOR VEHICLE COLLISION (DATE OF INJURY: / /20)

State Accident Occurred in: _____

Insurance Company: _____

Insurance Agent's Name: _____

Claim Number: _____

Is This Your Insurance Policy? YES ☐ NO ☐

If no, please provide policy holder's information

Is This a Third Party Claim? YES ☐ NO ☐

3) OTHER (PLEASE DESCRIBE): _____

HEALTH INSURANCE INFORMATION

1) Primary Insurance

Insurance Name: -_____

Group ID # _____ Subscriber ID# _____

2) Secondary Insurance

Insurance Name: _____

Subscriber ID # _____Subscriber ID # _____

3) Medicare #_____

4) Medicaid (N.J. Family case) ID # _____

SURGERIES/ MEDICATIONS/ ALLERGIES

Please List All Your Previous Surgeries and Approximate Year Performed

_____

_____

If You are Currently Taking Medication, Please List Names of Medication

_____

_____

Are you Allergic to Any Medications, Lotions, or Latex. Please List the Product and Its Effect on You.

_____

_____

PATIENT'S PERSONAL INFORMATION

How often do you drink alcoholic beverages?

Never / Rarely / Less than 5 drinks per week / More than 5 drinks per week

Do you use tobacco products? YES ☐ NO ☐ How many per day? ___

In what sports are you a regular participant? _____

Who is your primary care provider? _____ (City, State)

Which doctor referred you to us? _____ (City, State)

All patients, or their parent/legal guardian/personal representative, must provide their insurance or managed care membership card, and state or government issued photo ID, so Star Rehabs, Inc. may make copies for the patient record.

****

If any party to a lawsuit serves a subpoena for my and/or a dependent's treatment records related to health care treatment received at Star Rehabs Inc. then I agree to pay or agree to allow my attorney to pay a separate $1,200.00 fee per day for a representative's personal appearance in court, and additional travel costs if the round—trip distance traveled from facility to the trial location totals eight (80) miles or more, calculated at the federal mileage reimbursement rate at the time of travel.

_____

Print Full Name **Date**

_____

Signature of Parent, Legal Guardian, or Personal Representative