FISHER PHYSICAL THERAPY

PATIENT REGISTRATION FORM

Today's Date:	**Primary Care Physician**:

PATIENT INFORMATION

Patient's Last Name: First: Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital Status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

If under 18, name of parent/guardian:	Social Security Number:	Birth Date:	Age:	Sex: ☐ F ☐ M	Date of Injury:

Street Address:	Email Address:	Home Phone No.: ( )	Cell Phone No.: ( )

City:	State:	ZIP Code	Occupation:

Employer:	Work Status: FT ☐ PT ☐ Diem ☐ Disabled ☐ Retired ☐ Unemployed ☐ Other _____	Employer Phone No.: ( )

Referred by or choose this clinic because… (Please check one box):	☐ Dr.	☐ Insurance plan	☐ Hospital

☐ Family	☐ Friend	☐ Close to home/work	☐ Physician	☐ Other

Other family members seen here:	Have you been previously treated here: No ☐ Yes ☐ when: _____

INSURANCE INFORMATION

(Please give your insurance card and a picture ID to the receptionist.)

Name of Primary Insurance/Group no.:	Subscriber's Name:	Birth Date:	Home Phone No.: ( )

Occupation:	Employer:	Employer Address:	Employer Phone No.: ( )

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of Secondary Insurance (if applicable):	Subscriber's Name:	Group No.:	Policy No.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Motor Vehicle Accident: No ☐ Yes ☐ Date of accident:	**Work Related Injury**: No ☐ Yes ☐ Date of injury:

Attorney/Insurance Name:	Address:	Contact Phone No.: ( )

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to Patient:	Home Phone No.: ( )	Work Phone No.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Fisher Physical Therapy. I understand that I am financially responsible for any balance. I also authorize Fisher Physical Therapy or the insurance company to release any information required in processing my claims.

Patient/Guardian Signature _____ ***Date*** _____