PATIENT REGISTRATION FORM
ALLIED PHYSICAL THERAPY

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

_____
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 Parents Phone) **CELL PHONE** **MAY WE LEAVE MESSAGES?** **Computerized Appointment Reminders**

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

_____ _____ _____ ___ _____ _____
IF MINOR, GAURANTOR **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.***
- ***IN ORDER TO CONTROL COSTS, WE REQUIRE THAT ALL CO-PAYS AND DEDUCTABLES 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 Medical Intake 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)

(GUARDIAN PRINTED NAME) _____**DATE**_____