Client Registration Form

Date

Intake completed by:

Referral Source

CLIENT INFORMATION

Name:

S.S. #

D.O.B

Home Phone:

Cell Phone:

Email:

Address:

City

Zip

Emergency Contact

Relationship

Date of Injury

Diagnosis

ICD-10 (if known)

Description of Injury (DME, LvL of Injury, etc.)

Case Manger

Phone

Fax

Case Manager's Email

Case Manager's Address

Lawyer

Phone

Fax

Lawyer's Email

Lawyer's Address

MEDICAL INFORMATION

Referring Physician

Phone

Fax

Address

Script Written For:

PT

SLP

OT

Gym Membership

Other

INSURANCE INFORMATION

Insurance type

Health

Auto No Fault

Workers Compensation

Is your injury the result of an automobile accident?

Yes

No

Were you injured at work?

Yes

No

Have you received a request for an Independent Medical Examination (IME) or had an IME performed within the last year?

Yes

No

Have you received physical therapy anywhere else this year?

Yes

No

If yes where and for how long

Primary Insurance

Primary Insurance Billing Address

Subscriber

Relationship

SS#

Claim # if applicable

Policy # if applicable

Group # if applicable

Adjustor

Phone

Fax

Secondary Insurance

Secondary Insurance Billing Address

Subscriber | Relationship | SS#

Claim # if applicable | Policy # if applicable | Group # if applicable

Adjustor if applicable | Phone | Fax

Tertiary Insurance | Tertiary Insurance Billing Address

Subscriber | Relationship | SS#

Claim # if applicable | Policy # if applicable | Group # if applicable

Adjustor if applicable | Phone | Fax

ADDITIONAL INFORMATION

Day Of The Week Preferences

Monday Tuesday Wednesday Thursday Friday

Start Time Of Day Preference

6 am - 9 am 9 am - 11 pm 12:30 pm - 3:30 pm

Please note we close for lunch from 12 pm to 12:30 pm and we close at 4:30 pm and take our last appointment no later then 3:30 pm.

Additional Notes: