ez rehab
physical therapy, inc.

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NEW PATIENT REGISTRATION FORM

DATE:_____ IS THIS ACCIDENT RELATED? ___YES ___NO ARE YOU ON MEDICARE? ___YES ___NO

PATIENT INFORMATION

Last Name:	First Name:	MI:
Date of birth:	SSN:	Drivers License #:
Address:		
City:	State:	Zip:
Home Phone:	Work Phone:	Mobile:
Email address:	May we contact you by email? ___ Yes ___ No	
Mailing Address (if different)		
Marital Status: ___Single ___ Married ___ Divorced ___Student ___Other	Gender:	
Referring Physician:	Address:	Phone:

Injury Type: _____Auto Accident _____Work _____Other – Explain _____

Injury Date: _____ First Consulted: _____ Attorney Involved? __Yes __No

Attorney's Name: Address: Phone:

MEDICARE PATIENTS:
Have you had Physical Therapy this year? __Yes __No Have you had Home Health Care this year? __Yes__No

If Yes, please explain:

How did you learn about us? ____ Personal Referral by: _____

____Ad ____ Mailer ___ Internet Search (please indicate specific portal) _____

EMPLOYMENT INFORMATION

Current employer:	Status: ___ F/T ___ P/T ___Not Working ___ Retired	
Employer address:		Phone:
City:	State:	ZIP Code:

EMERGENCY CONTACT

Name:		
Current address:		
City:	State:	ZIP Code:
Phone:	Mobile:	Relationship

INSURED OR RESPONSIBLE PARTY (IF PATIENT IS A MINOR, GUARDIAN)

Primary Insurance Name:	Group #	Member #:
Insured's Last Name:	First Name:	MI:
Date of birth:	SSN:	Phone:
Address:		
Relationship to Patient:		
Secondary Insurance:		

CERTIFICATION

Patient's Signature (Guardian, if minor) Date: