Office Copy

Patient # _____

REGISTRATION FORM

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form.

If you do not understand a question leave it blank and your therapist will assist you.

NAME:	**Date of Birth:** ____/____/_____
Address:	
Phone Number: Home:( )	Cell phone: ( )
Email:	
Appointment contact preference: ( ) Home ( ) Cell ( ) Email	
Identification and Insurance:	( ) Copy of Drivers License (Both Sides) ( ) Copy of Primary Insurance Card (Both Sides) ( ) Copy of Secondary Insurance Card (Both Sides)
Emergency contact: Name:	Relation: Phone:
REFERRING MD:	**Phone:**
PRIMARY MD:	**Phone:**
Leisure activities: ( ) GOLF, ( ) Tennis, ( ) Runner, ( ) Others:	
Your Highest level of education: Doctoral ___ MA ___ BS/BA ___ AS ___ High School ___ Other_____	
Occupation: Retired Occupation _____	**Still working Occupation: _____**
Payment Information:	( ) Medicare ( ) Other Insurance ( ) Self Pay ( ) Other _____ (If Medicare or Other Insurance, Office Staff Complete Insurance Form)
How did you hear about us? ( ) Family/Friend ( ) Facebook ( ) Website ( ) Physician ( ) Other	