ACTS Occupational and Physical Therapy

Work Hard • Play Tough • Live Right

Patient Registration
Please Fill Out Completely

Name_____ Date _____
Last First MI

Address _____
Street City State Zip Code

Phone w/area code _____ Work Phone _____ Cell Phone _____

Email Address: _____ Check One: ___ Right Handed ___ Left Handed

Social Security Number _____ Birth date _____ Age _____ Sex: O female O male

Employer _____ Occupation _____

Referring Physician _____ Date of next visit _____ Primary Care Physician_____

Name of person who should receive statement (parent/guardian) _____

Statement address (if different than patient's address) _____

Emergency Contact _____ Relation _____ Phone number _____

INSURANCE INFORMATION

Primary Insurance

Insurance Co._____ Policy # _____ Group #_____

Patient Relationship to Insured _____ Policy Holder Name_____

Policy Holder SSN _____ Birth date _____ Phone w/ area code _____

Secondary Insurance (if applicable)

Insurance Co._____ Policy # _____ Group #_____

Patient Relationship to Insured _____ Policy Holder Name _____

Policy Holder SSN _____ Birth date _____ Phone w/ area code _____

IF YOU HAD AN ACCIDENT PLEASE COMPLETE THIS SECTION

Date of accident _____ How did it happen? O Auto O Work O other (location) _____

Involvement in Accident if Auto O Driver O Passenger O Pedestrian O Cyclist

Attorney/Case Manager Name _____ Claim Number _____

Billing Address _____

_____

Phone Number _____ ext. _____ Fax Number _____

Please tell us how you learned of our service or whom we can thank.

O I was a Former Patient
O Former Patient recommendation
O Doctor recommendation
O Family or Friend recommendation
O Insurance Company recommendation
O Employer recommendation
O Case Manager recommendation
O Newspaper advertisement
O Yellow Page advertisement
O Clinic Sign
O Web Page

Name _____