Client Registration Form

Patient Acct #_____Appt Date _____ Appt Time _____ Location _____

Treating Therapist _____ Body Part _____

Recent Surgery ____ Yes ____No Date of Surgery _____

Referral Source Dr Name/Address _____

How did you hear about us? (circle)

Friend/Family Sign Website Google TV (channel?) _____

Prior Patient Athletic Trainer Doctor's Order Other _____

First Name _____ Middle Initial _____Last Name _____

Home Address _____ City _____ State_____Zip _____

Home phone _____Cell_____ Work _____

Email Address _____ Date of Birth _____

Gender ____ Male ____ Female

If under 18, who is responsible/guarantor for account _____Relationship to Patient _____

Primary Health Insurance Company

Insurance Company Name _____ Phone _____

Member ID # _____ Group # _____

Policyholder Name (if other than patient) _____ Policyholder DOB _____

Patient relationship to policyholder _____ Patients social security #_____

Secondary Health Insurance Company (if applicable)

Insurance Company Name _____ Phone _____

Member ID # _____ Group # _____

Policyholder Name (if other than patient) _____ Policyholder DOB _____

Patient relationship to policyholder _____

Workers Compensation, Auto Insurance or Personal Liability Insurance (if applicable)

How were you injured (circle one) ____Work ____ Auto ____Liability Date of Injury _____

Employer at time of injury_____

Adjuster's Name _____ Adjuster's Phone number _____

Insurance Carrier Name and Address _____

Visits ordered by MD File or Claim Number State accident occurred