FUSION ARTS PHYSICAL THERAPY

PATIENT REGISTRATION FORM

Date of First Visit _____ Time: _____ Date of Injury/Onset/Surgery: _____

Patient's Name: _____ Date of Birth: _____

Social Security #: _____ Marital Status: S M D W DL#: _____

Address: _____ Apt #:_____

City: _____ State: _____ Zip: _____

Sex: Male Female Type of Accident: Auto Work Other Date of Accident:_____

Home Phone #:_____ Work Phone #:_____

Cell Phone #: _____ Email Address: _____

Employer Name: _____

Employer Address:_____ City: _____ State:_____ Zip:_____

In case of emergency: _____ Phone #: _____ Relationship: _____

Referring Physician: _____ Phone #: _____

Date of last MD Visit: _____ Diagnosis: _____

Prescription Frequency & Duration: _____

Referring Attorney: _____ Phone #: _____

Attorney Address: _____

City, State, Zip: _____

Have you had PT, OT, Speech, Chiro, Accupuncture this year? _____ How many visits? _____

If this is a Medicare patient ask if they are enrolled in Medicare Home Health? YES NO

PRIMARY INSURANCE INFORMATION

Insurance Carrier: _____ Phone #: _____

Insured Name: _____ ID #:_____

Insured Date of Birth: _____ Insured Social Security Number: _____

Group #: _____ Policy #:_____ Claim #: _____

Is this Plan and Individual or Group Plan: _____

Adjustor Name: _____ Phone #: _____

SECONDARY INSURANCE INFORMATION

Insurance Carrier: _____ Phone #: _____

Insured Name: _____ ID #:_____

Insured Date of Birth: _____ Insured Social Security Number:_____

Group #: _____ Policy #:_____ Claim #: _____

Information taken by: Date: _____