

FUSION ARTS PHYSICAL THERAPY - PATIENT REGISTRATION FORM

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

Patient's Name: _____ Date of Birth: _____

Preferred Gender Pronouns: (he/him/his) (she/her/hers) (they/them/theirs) -or- _____

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: _____