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- _____

Marital Status: Single Married Divorced Widowed Drivers License #: _____

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: _~~