ULTIMATE REHAB, LLC

DATE: _____ **REGISTRATION FORM**

1. Patient Name: _____

2. Address: _____

3. City: _____ **State:** _____ **Zip:** _____

4. Date of Birth: _____ **Social Security #:** _____

5. Work #: _____ **Home #:** _____

6. Email: _____ **Cell #:** _____

7. Marital Status: ⬭ **Married** ⬭ **Single** ⬭ **Widowed** ⬭ **Divorced**

8. Student: ⬭ **Yes** ⬭ **No** **9. Gender:** ⬭ **Male** ⬭ **Female**

10. Employer Name: _____ **Occupation:** _____

11. Employer Address: _____

12. City: State: _____ **Zip:** _____

13. How did you find out about us? _____

Name of referring Physician: _____ **(required for PT)**

Address: _____

City: _____ **State:** _____ **Zip:** _____ **Tel.#:** _____

15. Purpose of visit (DX): _____

16. Have you seen another physical therapist this year? ⬭ **Yes** ⬭ **No**

17. Primary insurance Company: _____ **Tel#:** _____

18. Policy Holder: _____ ⬭ **Self** ⬭ **Spouse/Partner** ⬭ **Guardian**

19. D.O.B: _____ **SS#:** _____ **TEL:** _____

20. Policy #: _____ **Group#:** _____

STAFF ONLY

21. Lawyer Name: _____ **TEL#:** _____

22. Lawyer Address: _____

23. City: _____ **State:** _____ **Zip:** _____

Date: _____ **IN NETWORK** **OUT OF NETWORK**

Eff Date: _____

Deductable: _____ **Ded Met?:** _____ **Out of pocket:** _____

Benefits: _____ **%** **Co Insur** _____ **%** **Co-payment/Fee** _____ **Visits per year:** _____

Precert/Auth required: _____ **Phone #:** _____

Name of insurance rep: _____

Verified By: _____ **Date:** _____

First appointment: _____ **Time:** _____ **Therapist:** _____

Notes: _____

_____