Steel Valley Physical Therapy

Patient Registration Form

Today's Date: _____ Referring Doctor: _____

Date of Follow-up Appt. with Dr: _____

1. Patient's Last Name_____ First _____ MI __

Address _____

City_____ State_____ Zip Code_____

Home # _____ Work #_____ Ext. _____

Cell # _____ May we leave a message? _____

SS# _____ DOB _____ Age_____ Sex: M or F

Emergency Contact (outside of your home, neighbor, friend or relative):

Contact Name and #:_____

2. Name of Patient's Employer _____

Employer Address _____

City _____ State_____ Zip Code_____

Occupation_____

3. Parent's Information (if patient is under the age of 17)

Last Name _____ First _____ MI _____

Address (If different from above) _____

City _____ State_____ Zip Code_____

Home# _____ Work# _____ Ext. _____

DOB _____ SS#_____

4. Primary Insurance Name _____

ID# _____ Group# _____

Are you the subscriber? Y or N If NO, name of subscriber_____

Patient's relationship to subscriber _____

SS# (of Subscriber)_____ DOB (of subscriber) _____

5. Secondary Insurance Name_____

ID# _____ Group# _____

Are you the subscriber? Y or N If NO, name of subscriber_____

Patient's relationship to subscriber _____

SS# (Subscriber)_____ DOB (of subscriber) _____

6. Date of Injury (if applicable) _____

7. Auto Insurance (if injury was due to automobile accident)

Auto Insurance Co._____Name of Insured_____

Address _____

City_____ State _____ Zip Code _____

Policy # _____ Claim # _____

Adjustor's Name_____ Phone # _____

8. Worker's Compensation (if work related injury)

Are we a panel provider? _____

Name of Employer (at time of injury) _____

Worker's Comp. Insurance Co._____

Address _____

City _____ State _____ Zip Code _____

Claim # _____

Adjustor's Name _____ Phone# _____

9. How did you hear about Steel Valley Physical Therapy?

Doctor_____ Friend/Family_____

Insurance Co. _____ Other_____