MOUNT HOPE PHYSICAL & AQUATIC THERAPY

Patient Registration Form

Name

_____

Address_____

_____

Primary Phone (_____) _____Secondary Phone (_____)

_____

Date of Birth _____/_____/_____ Gender Male ___Female___

If under 18 who is responsible for this account?

_____

Social Security # _____ _____ _____ (Required for Medicare, WC, MVA)

Email

_____

Emergency Contact

_____

Phone (____) _____ Relationship

_____

Are you Employed? Yes ___No ___ Retired ___ Disabled _____ Other ____

Employer Name _____Phone (____)_____

How did you hear about Mount Hope Physical & Aquatic Therapy? Please Choose One

My Doctor ____ Family/Friend ____ Website ____ Mailing Ad ____ Online Ad ____ Facebook____

Referring Physician Name

_____

Primary Care Physician (PCP)

_____

Have you had Physical Therapy in the current year? _____Yes _____No

Diagnosis (or body part to be treated): _____Left____ Right____

Is this Related to a recent Surgery? Yes ___ No ___ If Yes Date of Surgery _____/_____/____ Did you have Home healthcare for this surgery? Yes ___No___ Discharge Date ____/____/____

HEALTH INSURANCE INFORMATION

Primary Insurance _____ **Subscriber ID#**_____

Are you the subscriber? Yes__ No__

Subscriber Name _____Date of Birth___/___/____Relationship_____

Secondary Insurance _____ **Subscriber ID#**_____

Are you the subscriber? Yes__ No__

Subscriber Name _____Date of Birth ___/___/____ Relationship_____

Tertiary Insurance _____**Subscriber ID#**_____

Are you the subscriber? Yes___ No___

Subscriber Name _____ Date of Birth ___/___/____ Relationship_____

INJURY INFORMATION

Is this an injury related to an accident? Yes___ (please provide info) No___ (please sign below)

Accident Type Auto Accident ____ Workers Compensation___ Slip N Fall _____ Other _____

Where is your pain?_____

Pre-Authorization is required for WC. Has Worker's Compensation accepted your claim? Yes___No___

Date of Injury ___/___/____ State Which Injury Accrued _____ Report filed? Yes ___ No___

Pre-Authorization is required for WC. Has Worker's Compensation accepted your claim? Yes___No___

Insurance Name _____ Claim Number _____

Adjuster Name _____ Phone (___) _____ Fax (___) _____

Do you have an attorney representing your claim? Yes ____ (Please see Lien Form) No____

Attorney _____ Law Firm _____ Phone (___) _____

Patient/Guardian Signature_____
Date___/___/____