PATIENT REGISTRATION

FOCUS PHYSIOTHERAPY

TODAY'S DATE: _____ Appointment Date: _____ Time: _____

Diagnosis: _____

Last Name: _____ First Name: _____ MI: ____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____)_____ Alternate Phone:(____)_____

Emergency Contact: _____ Phone:(____)_____

Date of Birth:_____ Sex: M F SS#:_____

Referring Doctor:_____ Primary Care Doctor:_____

Primary Insurance Company:_____

Name of Insured:_____Relation to Patient:_____

Insured's Date of Birth:_____

Policy Number:_____Group Number:_____

Secondary Insurance Company:_____

Name of Insured:_____Relation to Patient:_____

Insured's Date of Birth:_____

Policy Number:_____Group Number:_____

Tertiary Insurance Company: _____

Is this a Workers' Compensation Claim? Yes No Date of Injury:_____

Case Manager:_____Phone:_____ Fax:_____

Adjustor:_____Phone:_____ Fax:_____

Billing Address:_____

Approved Visits:_____Expiration Date:_____Per _____Claim Number:_____

Medicare Patients – Are you currently receiving any home health services? Yes or No
Medicare Patients can not receive outpatient PT/OT while receiving any type of home health services.