HolistiCare
Physical Therapy, LLC

Patient Registration Form – Please complete via Print or E-mail

New Patient? Yes____ No____ Today's Date: __________________

How did you find our clinic? Physician_____Relative/friend_____Internet______Other______

Patient Information

Name:____

Birthday:___________________Age:____________ Gender: Male______ Female________

Address: ____

City/State/Zip code: ____

Phone (mobile): __________________________(home)_____________________________

Email:____

Date of injury/ Onset date: _____________ Diagnosis: ______________________________

Medicare: yes_____no_____

If yes, have you received PT/speech services since 1/1 of this year? Yes_____no______

Auto related: yes_____no_____

If yes, Adjustor Name: ______________Phone #:______________

Work Related: yes___no___ If yes, was it with current employer? Yes_____ no______

Case Worker Name and Phone #:_________________________

Primary Insurance Information

Name of Insurance Company:______________________ Policy #:_____________________

Group/Plan #:_____________________ Policy Holder Name:________________________

Date of Birth: _____________________ Policy Holder's Employer: ____________________

Patient relationship to Policy Holder: Self_____ Spouse____Dependent______Other_______

HolistiCare
Physical Therapy, LLC

Secondary Insurance Information

Name of Insurance Company:________________________ Policy #:___________________

Group/Plan #:_____________________ Policy Holder Name:_________________________

Date of Birth: _____________________ Policy Holder's Employer: _____________________

Patient relationship to Policy Holder: Self____Spouse_____Dependent______Other_______

Employer Information

Employer Name:____________________Employer Phone #:__________________________

Employer's Address:_________________________City/State/Zip:______________________

Occupation:_____________________ Employment Status: ___________________________

Physician Information

Name of Physician:_______________________Phone #: ____________________________

Fax #__________________________ Physician address_____________________________

City/State/Zip:____

Emergency Contact Information

Contact Name:________________________ home phone #:_______________________

Cell phone #:_________________________ Relationship to patient: ___________________

I hereby authorize HolistiCare Physical Therapy through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures relating to the diagnosis stated by my referring Physician.

I further authorize HolistiCare Physical Therapy to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

____

Signature Date