# Physical Therapy and Fitness Center

Confidential Registration Form

**Name:**_____ **DOB:**_____

**Address:**_____ **City:**_____ **ZIP:**_____

**SS#**_____ **Male/Female Status:Married/Divorced/Single/Other**

**Email:**_____

**Date of onset:**_____ **Date of Surgery( if applicable):**_____

**Employer:**_____ **Occupation:**_____

**Cell#**_____ **Home#**_____ **Work#**_____

**Referring MD:**_____ **Phone #**_____

**PCP:**_____ **Phone#**_____

**Primary Health Insurance:**_____ **Subscriber ID:**_____

**Subscriber Name:**_____ **Subscriber DOB:**_____

**Subscriber Employer:**_____ **Phone #**_____

**Secondary Health Insurrance:**_____ **Subscriber ID:**_____

**Subscriber Name:**_____ **Subscriber DOB:**_____

**Subscriber Employer:**_____ **Phone #**_____

**Is this injury work related?**____ **If YES:Insurance Co.**_____

**Phone#**_____ **Date of Injury**_____ **Claim#**_____

**Is this Auto Accident Related?**___ **If YES:Insurance Co.**_____

**Phone#**_____ **Date of Injury**_____ **Claim#**_____

**Adjuster Name:**_____ **Extension:**_____

**Attorneys Name:**_____ **Phone#**_____

**How did you hear about our Facility?**

**MD__friend__family__previous PT__Internet__advertisement__other__**

**You are responsible for keeping your scheduled appointments.**

**Do you want reminder phone calls? Yes**_____ **No**_____