Cornerstone Physical Therapy LLC

Patient Registration Form

Patient's Name: ______________________________

Street ______________ Town ______________ State _____ Zip _____

Home Tel. # ______________ Work Tel. # ______________

Cell Tel. #______________ Email Address: ______________

SSN: ______________ Date of Birth: ______________

Marital Status: S M W D

Have you received any physical therapy this year? ______________

On-Set date of problem:______________ Date Last seen by your doctor: ______________

Are you currently in the Military Yes________ No __________ (please initial)

IN CASE OF AN EMERGENCY PLEASE CONTACT:

Name______________________**Relationship**__________ **TEL#**____________________

NAME OF RESPONSIBLE PARTY: (parent, guardian, etc.)

Name:______________________________

Street ______________ Town ______________ State _____ Zip _____

Tel. # ______________ Relationship: __________ Date of Birth______________________

YOUR EMPLOYER INFORMATION:

Company Name:______________________ self emp. (Y or N)

Street ______________ Town ______________ State _____ Zip _____

PRIMARY INSURANCE COVERAGE:

Insured Name: ______________________ Relation to insured ______________

Name of Insurance Company: ______________________________

Group Policy Number:______________________ Membership ID #: ______________

Ins. Co Tel. # ______________________

SECONDARY INSURANCE COMPANY:

Insured Name: ______________________ Relation to insured: ____________

Name of Insurance Company: ______________________

Group Policy Number ______________________ Membership ID #: ____________

Ins. Co Tel. # ______________________

WORKER COMPENSATION

ONLY COMPLETE THIS SECTION IF A JOB RELATED INJURY

Date of Injury: __________ Did you file a claim with your employer? Yes No

Have they accepted responsibility for your medical bills? Yes No

Who was your employer at the time of injury? ______________________

Street ______________ Town ______________ State ________

Responsible Person: ______________ Claim # ______________

Phone #: ______________ Ins. Co. Tel. # ______________

NO FAULT CLAIM

ONLY COMPLETE THIS SECTION IF AN AUTOMOBILE-RELATED INJURY

Date of Accident: Town of Accident:

Insured's Name: ______________ Policy #: ______________

Claim #: ______________ Insurance Co.: ______________

Ins. Co address ______________ Town ______________ State ________

Phone # __________ What is the limit of Policy Coverage? $ __________

What dollar amount has been used to date? ______________________

Attorney Name ______________________

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or the party who accepts assignments.

______________________ ______________

Please sign (Insured or authorized party) **Date**