Prestige
Physical Therapy

Patient Registration

PATIENT

PLEASE PRINT LEGIBLE ON FORM

Have you had prior therapy for this injury?

Last Name:	First Name:		Middle Initial:
Address:	City:	State:	Zip:
Home Phone:	Mobile Phone		Work Phone
DOB:	Gender:		SSN#
Referring Doctor:	Phone:	Address:	
Employer Name:	Address:		

EMERGENCY CONTACT

Last Name:	First Name:	
Home Phone:	Mobile Phone:	Work Phone:
Relation to patient:		

GUARANTOR / RESPONISIBLE PARTY (fill out if patient is a minor)

Last Name	First Name		Middle Initial
Address	City	State	Zip
Home Phone:	Mobile Phone:		Work Phone:
DOB:	Gender :		SSN#
Employer Name:	Address:		
Relation to patient:			

PRIMARY INSURANCE (copy of card must be on file) Check Here if Name, SSN & DOB same as patient _____

Insurance Name:	Member #	Group #
Subscriber (insured) Name:	SSN#	
Relation to patient:	DOB:	

SECONDARY INSURANCE (copy must be on file) Check here if Name, SSN & DOB same as patient _____

Insurance Name:		
Subscriber (insured) Name :	SSN#	
Relation to patient:	DOB:	

ACCIDENT (if applicable)

Work related? Auto or other Type Accident? (If yes, please fill out below)

Insurance Name:		Phone	
Address :	City:	State:	Zip:
Policy#			Agent/Adjuster Name
Claim#	Accident Date		Accident State