PELTZ AND ASSOCIATES
PHYSICAL THERAPY INC

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last Name:_____ First Name:_____ MI:____ Sex: ☐ M ☐ F

Address:_____ City:_____ State:_____ Zip:_____

Birthdate:_____ SS #:_____ E-mail:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Occupation:_____ Employer (If under 18, put parent's employer):_____

Address:_____ City:_____ State:_____ Zip:_____

Marital Status: ☐ S ☐ M ☐ Other Spouse's Name:_____ Work Phone:_____

Spouse's Employer:_____

Address:_____ City:_____ State:_____ Zip:_____

EMERGENCY CONTACT INFORMATION

Name:_____ Relationship:_____

Home Phone:_____ Address:_____

REFERRING PHYSICIAN INFORMATION

Name:_____ Phone #:_____

Address:_____ Fax #:_____

PRIMARY PHYSICIAN INFORMATION

Name:_____ Phone #:_____

Address:_____ Fax #:_____

PRIMARY INSURANCE COMPANY INFORMATION

Insurance Name:_____ Identification #:_____

Group #:_____ Address:_____

Phone #:_____ Policyholder:_____

Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other SS #:_____ DOB:_____

SECONDARY INSURANCE COMPANY INFORMATION

Insurance Name:_____ Identification #:_____

Group #:_____ Address:_____

Phone #:_____ Policyholder:_____

Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other SS #:_____ DOB:_____

AUTOMOBILE ACCIDENT/PERSONAL INJURY CASE

Claim Number:_____ Adjuster Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Policy ID #:_____ Lien: ☐ Yes ☐ No

Attorney's Name/Address:_____ Phone:_____

Please present your insurance card to the front office staff so we may copy for our records