For Office Use Only:

Acct#___________ **Start / Restart Date**________________

Prescription Date: ________________ **Therapist**____________

Patient Registration Form

PERSONAL INFORMATION

Patient Name____
First Middle Initial Last

Date of Birth _____/_____/_____
MM DD YY

Address____
Street, PO Box Apt#

Sex: Male Female
(Circle One)

Status: Single Married Other
(Circle One)

____
City State Zip Code

Patient's Employer / School________________________

Home Phone (   ) _________________**Cell** _______________

Work Phone (   ) _______________________________
**May we contact you at work? Yes No
(Circle One)

Email Address ____
Please provide, as we send educational and promotional information

Address____
Street, PO Box Suite#

____
City State Zip Code

Parent Name __________________________________
(If under age 19)

Patient's Occupation_______________________________

****Emergency Contact****__________________________________

Student: Yes No
(Circle One)

Phone (   ) ______________________________________

HOW DID YOU HEAR ABOUT US? (please circle) Doctor Family Friend
Coach Social Media TV Publications Self Other

If Yes: Full-time Part-time
(Circle One)

Is Your Reason For Being Seen:
****Work Related**: Yes or No (**circle one**) **Cause of Injury:** ______________________ **Date of Injury**: ____________________

****Motor Vehicle Accident**: Yes or No **State of Accident**: ____________________ **Date of Accident**: ________________

Have you received Home Health Care OR Physical Therapy in the past year? Yes or No (circle one)

If yes, have you been released from care? Yes or No (circle one)

Number of visits used for Home Heath_______ **Number of visits used for PT**_________

If necessary, may we leave a message regarding appointment time, changes of, or scheduling information:
_____ on answering machine _____ on voice mail _____ with a family member _____ at work

I give my permission for the following to obtain treatment and/or billing information associated with my treatment at Alliance Physical Therapy, LLC:

Spouse: ______________________ Parent: ______________________ Child(ren): ______________________

Employer: ____________________ Other: ______________________

Signature ____ Date __________________________
Note. If you are 19 years of age or younger, a parent or guardian must sign this patient registration form on your behalf