



PELTZ AND ASSOCIATES
PHYSICAL THERAPY INC

PATIENT REGISTRATION FORM

PATIENT INFORMATION			
Last Name: _____	First Name: _____	MI: _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Address: _____	City: _____	State: _____	Zip: _____
Birthdate: _____	SS #: _____	E-mail: _____	
Home Phone: _____	Work Phone: _____	Occupation: _____	
Employer Name (If under 18, put parent's employer): _____			
Address: _____	City: _____	State: _____	Zip: _____
Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> 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 INSURANCE COMPANY INFORMATION			
Insurance Name: _____	Identification #: _____		
Group #: _____	Address: _____		
Phone #: _____	Policyholder: _____		
Relationship: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	SS #: _____	DOB: _____	
SECONDARY INSURANCE COMPANY INFORMATION			
Insurance Name: _____	Identification #: _____		
Group #: _____	Address: _____		
Phone #: _____	Policyholder: _____		
Relationship: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	SS #: _____	DOB: _____	
WORKER'S COMPENSATION/AUTOMOBILE ACCIDENT/PERSONAL INJURY CASE			
Claim Number: _____	Adjuster Name: _____		
Address: _____	City: _____	State: _____	Zip: _____
Phone: _____	Policy ID #: _____	Lien: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Attorney's Name: _____		Phone: _____	
Attorney's Address: _____			
Please present your insurance card to the front office staff so we may copy for our records			