FORT LEE PHYSICAL THERAPY

PATIENT REGISTRATION FORM (PLEASE PRINT CLEARLY)

PATIENT INFORMATION	
Name (First, Last)	**Home Address**
Date of Birth	
Social Security	
Gender (circle) Male Female	**Home Phone**
Marital Status (circle) Single Married Other	**Mobile Phone**
How did you find out about us? (circle) Doctor Family Friend Internet Other _____	
Have you had treatment (speech or physical therapy) within the current year? Yes No	
If yes, was it in an in-patient office or out-patient office?	
EMERGENCY CONTACT INFORMATION	
Name	**Home Phone**
Relationship to you	**Mobile Phone**
EMPLOYMENT INFORMATION	
Employment Status (circle) Full-Time Part-Time Unemployed Retired	
Disability Status, if applicable (circle) Temporary/Short-Term Permanent/Long-Term	
Employer Name	**Employer Address**
Work Phone	
Occupation	
DOCTOR and INURY INFORMATION	
Referring Physician	**Referring MD Phone Number**
Date of last visit to Referring MD	**Referring MD Office (City/Town)**
Primary Care Physician	**PCP Phone Number**
Date of last Visit to PCP	**PCP Office (City/Town)**
Date of Injury	**Date of Surgery, if applicable**
INSURANCE INFORMATION (IF NOT WORK RELATED OR MOTOR VEHICLE ACCIDENT)	
Primary Insurance	**Secondary Insurance, if applicable**
Primary Member ID	**Secondary Member ID**
Name of insured if not self	**Name of insured if not self**
Insured's Date of Birth	

I, (PRINT NAME) _____, authorize Fort Lee Physical Therapy to treat me as per my doctor's prescription and to release my insurance company/lawyer/employer any information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims for benefits.

Patient Signature _____ Date_____