Amelia Physical Therapy Patient Registration Form

Where you are treated like family

Patient Name_____Gender: _____
Last First Middle Initial Nickname

Street Address _____

City _____ State _____ Zip Code _____

Phone (H) _____Phone Work _____Phone Cell _____

Date Of Birth __/___/_____ Soc. Security #_____-____-_____Marital Status_____

Email or Text Reminder? (Circle one and, if text reminder, provide carrier): Cell Carrier: _____

*Email Address_____ so we can send you a survey at end of treatment.

Employer _____ Address _____

Insurance Plan _____ How did you find out about this practice? _____

(Skip if policy holder is same as above) **Policy Holder's Name**_____ Date of Birth_____

Address of Policy Holder _____Relationship: _____

Auto Accident? _____ *State Occurred* _____ *Date of Injury or Surgery* ___/___/___ *Workers Comp?* _____

Name of referring doctor and date of next follow up: _____

****IF YOU ARE COMING DIRECT ACCESS PLEASE FILLTHIS PORTION OUT****

DIRECT ACCESS Yes No Chief Complaint _____

Are you under a doctor's care? _____ Doctor's name _____

I give consent to release all records to my Doctor of record (If identified above)
Medicare and United Healthcare require a prescription from the doctor.

Signature: _____Date:_____

Emergency Contact: Name_____Relationship_____

Phone (H)_____(W)_____ (C)_____

Have you had any type of Therapy this year? _____

If mailing address is different than street address, please write the mailing address below:

_____