GEER PHYSICAL THERAPY

OUTPATIENT REGISTRATION FORM

PATIENT NAME_____

MAILING ADDRESS:_____

_____

HOME PHONE: _____ **WORK PHONE:** _____ **CELL:** _____

DATE OF BIRTH: _____ **IF MINOR, PARENT'S NAME:** _____

PARENT'S DATE OF BIRTH: _____

EMERGENCY CONTACT: _____ **PHONE:** _____

EMAIL: _____ *(Use for Health Related Newsletter)*

INSURANCE INFORMATION - Please Provide All of Your insurance Cards:

Subscriber Name: _____ **Subscriber SS#** _____

Subscriber Date of Birth: ____/____/____ **Subscriber ID #** _____

Name of Insurance _____**Name of Additional Insurance:** _____

Address: _____

PRIMARY CARE PHYSICIAN: _____

REFERRING PHSYICIAN: _____

_____ _____

Signature **Date**

WORK RELATED INJURY: Is your condition under Workman's Compensation? ☐ **Yes** ☐ **No**

MEDICARE PATIENTS: Are you currently enrolled in Home Health or VNA services? ☐ **Yes** ☐ **No**

If Yes: (List Company Name) _____

AUTO ACCIDENT:

If you want us to bill for an auto accident, we will do so. We ask that you present us with your private health insurance information as backup. I realize that if my auto benefits should be denied or exhausted that I would be responsible for any charges incurred.