Duanesburg Physical Therapy

Registration Form

Name_____

Date of Birth _____/_____/_____ Patient's SS#_____

Address_____City_____

State_____ Zip_____ Home Phone _____Cell_____

Do we send mail to this address? YES___NO___ If not where:_____

Female __ Male___ Single___ Married___ Divorced __ Other _____

Employer:_____ Employer Phone:_____

Email Address:_____ Reminder Msg. Type: __Text-cell; __call-cell; __call-home;__none

Student YES ___ NO __ School:_____

Emergency Contact: _____Relationship: _____Phone:_____

Referring Physician_____Phone_____

Primary Physician_____Phone_____

Injured/affected area _____Date of injury/onset of pain_____

Surgery YES ___ NO ___ If yes, type? _____Date _____

How did you hear about Duanesburg PT? (Please Circle One)

Doctor Drive-By Friend Newspaper/Radio Previous PT Yellow Pages Seminar

Is condition related to: Employment YES ___ NO __ Auto Accident YES __ NO __

Other Accident? YES __ NO__ Explain:_____

Primary Insurance Company:_____ Phone#_____

Address of Insured (if not the same as Patient)_____

Name of Insured_____DOB_____SS#_____

Relationship to insured Self __ Spouse__ Child __ Home Phone #_____ Copay _____

Group # or Name_____ ID /Claim#_____

Secondary Insurance Company:_____ Phone#_____

Name of Insured_____DOB_____SS#_____

Relationship to insured Self ___Spouse ___ Child ___ Home Phone #_____Copay_____

Group # or Name _____ID/Claim#_____