PATIENT REGISTRATION

Welcome to our clinic. In order to serve you properly, we will need the following information. **(Please Print)**
All information is strictly confidential.

Patient's Name	Sex ☐ M ☐ F	Age_____ Birth Date____/____/_____	Patient's Social Security #
Residence Address		Home Phone Cell Phone	Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced
Name of Employer Address		Business Phone	Occupation
Person financially responsible for this account	☐ Self ☐ Spouse ☐ Other	Responsible Party's Birth Date ____/____/_____	Responsible Party's Social Security #
Person to Contact in Case of Emergency		Relationship to Patient	Phone
E-mail Address (*for purposes of receiving newsletters)*		How did you hear about us?	Whom may we thank for referring you?

Medicare ☐ Yes ☐ No	Medicare #	Medicaid ☐ Yes ☐ No	Medicaid #	Effective Date
Secondary insurance name Address			Policy #	Group #

Workers' Compensation? ☐ Yes ☐ No Motor Vehicle? ☐ Yes ☐ No **If Yes-put W/C or MVA carrier below**	Date of Accident	W/C or MVA Contact Person	W/C or MVA Insurance Phone #
Primary Insurance Company Address		Claim #	Is insurance through your employer? ☐ Yes ☐ No
Subscriber Name	Subscriber Birth Date	Policy #	Group #
Are you currently receiving rehab services through another agency? ☐ **Yes** ☐ **No** (Other agencies may include home health, outpatient clinics or hospital) **If yes, please provide name and phone number of agency:**			If **Yes**, what services are you receiving?

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge and agree that I have received a copy of the Lakewood Physician Therapy Notice of Privacy Practices.

_____ _____
Patient, Parent or Guardian Signature (if child is under 18 years old) Date