Berryville
Physical Therapy and Wellness

PATIENT REGISTRATION **Date:**_____

***Last Name:** _____ ***First Name** _____ **MI:** ____ ***M/F Marital Status** _____

***Street Address:**_____ **Mailing Address** _____

***City:** _____ **State:** _____ **Zip:**_____ **E-Mail:**_____

(FOR APPOINTMENT REMINDERS)

***Date of Birth:** ____/____/____ ***SSN** _____-_____-_____ **or Drivers License #**_____

If the patient is a minor, what is the custody situation? *Joint *Father** _____Mother**_____

***Home Phone: (**_____**)** _____-_____ **Cell Phone (**_____**)** _____-_____ **Primary ~ Home / Cell**

***Emergency Contact Name** _____ **Relationship** _____**Ph #**_____

***EMPLOYMENT** ____ **Full Time** ____ **Part Time** ____**Retired WK PH#**_____

***HAS THE PATIENT HAD ANY OTHER THERAPY THIS YEAR? Y / N When?** _____**Where?**_____

***CASE**

ICD-9 Diagnosis / Medical Reason for coming _____ **Related cause** _____

Referring Physician _____ **Return to Dr date**_____/_____/_____ ***Assigned PT** _____

Post Op? Y / N Date of Surgery_____/_____/_____ **MVA? Y / N Date** _____/_____/_____ **State** _____

***PRIMARY INSURANCE INFORMATON**

Who is the Insured? Self ( ) Spouse ( ) Parent ( ) Other ( )

***Insurance Company Name:** _____ ***Ins Ph #** _____

***Subscriber's Full Name** _____ ***Subscriber's DOB** _____/_____/_____

***Subscriber's SSN** _____-_____-_____ ***Ins ID #** _____ ***Group #**_____

Effective Date ____/____/____ **Co-pay Amt.** _____ **or % of Co-Insurance** _____ **Deductible** _____

SECONDARY INSURANCE INFORMATON (If Applicable)

*** If Medicare is Second, what is the status of the first? Patient or Spouse have Ins through job?**_____

Who is the Insured? Self ( ) Spouse ( ) Parent ( ) Other ( )

Insurance Company Name : _____ **Ins Ph #** _____

Subscriber's Full Name _____ **Subscriber's DOB** _____/_____/_____

Subscriber's SSN _____-_____-_____ **Ins ID #** _____ **Group #**_____

Effective Date ____/____/____ **Co pay Amt.** _____ **or % of Co-Insurance** _____ **Deductible** _____

***Make sure patient is not in home health when they come for outpatient PT – they will be liable for the visit ***

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