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 ___________-_________-____________

*Home Phone: (______) _______-_____________ *Cell Phone (______) _______-_____________ Primary ~ Home / Cell

*Emergency Contact Name _____________________________ Relationship _______________Ph #__________________

*PLACE OF EMPLOYMENT ____ or ___ Retired

*WORK ADDRESS _______________________________________ WK PH#______________________________

*HAS THE PATIENT HAD ANY OTHER THERAPY THIS YEAR? Y / N When? _______Where?_______________

* How did you hear about us? _____________________________ Referred by whom?___________________________

***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 – or they will be liable for the visit ***

322-A North Buckmarsh St. Berryville, VA 22611 540.955.1837 Fax 540.955.1838 www.berryvillept.com

effective 6.1.2016