Physical Therapy 160 Flynn Avenue ● Burlington, Vermont 05401 ● Phone 802 864-6262 ● Fax 802 864-6252

PATIENT REGISTRATION FORM

DATE ____________

PATIENT NAME *(FIRST)* ______________________ *(MI)* ______ *(LAST)* ___________________________

ADDRESS ____

CITY ___________________________________ STATE _______________ ZIP _______________

DATE OF BIRTH ___ ___ / ___ ___ / ___ ___ ___ ___ SEX ____ M ____ F SS # ___ ___ ___ / ___ ___ / ___ ___ ___ ___

PHONE *(HOME)* _______________________ *(WORK)* _______________ *(CELL)* ____________________

EMAIL ADDRESS: ____

EMPLOYER __________________________ JOB TITLE ______________ *(FULL TIME)* _____ *(PART TME)* __________

STUDENT _____ NO ____ YES *(WHERE)* _____________________________ *(FULL TIME)* _____ *(PART TME)* _______

EMERGENCY CONTACT ________________________ *(PHONE)* _____________ *(RELATIONSHIP)* ____________

INJURY / ACCIDENT DATE ____

REFERRING DOCTOR:

(FIRST) _________________________ *(LAST)* ______________________

(CITY) __________________________ *(STATE)* ______________________

__ APN __ APRN __ ARNP __ CNM __CRNP
__ DC __ DDS __ DMD __ DO __ DPM __ DPT
__ FNP __ LAc __ MD __ ND __ OD __ OT __ PA
__ PAC

PRIMARY CARE PHYSICIAN:

(FIRST) _________________________ *(LAST)* ______________________

(CITY) __________________________ *(STATE)* ______________________

__ APN __ APRN __ ARNP __ CNM __CRNP
__ DC __ DDS __ DMD __ DO __ DPM __ DPT
__ FNP __ LAc __ MD __ ND __ OD __ OT __ PA
__ PAC

HOW DID YOU HEAR ABOUT US? ___________________________________

IF A FRIEND, PLEASE TELL US WHO SO WE MAY THANK THEM ____

PRIMARY INSURANCE INORMATION:

TYPE OF INSURANCE ____ WORK COMP ____ MEDICAID ____ MEDICARE ____ GROUP ____AUTO (MVA)

INSURED / POLICY HOLDER NAME *(FIRST)* ____________________ *(MI)* ____ *(LAST)* _________________________

RELATIONSHIP ___SELF___SPOUSE ___MOTHER ___FATHER ___OTHER

*(ADDRESS)*________________________________ *(CITY)* _____________________ *(STATE)* _____ *(ZIP)* _______

(HOME PHONE) __________________ *(WORK)*_______________ (SS#) _______________ *(DATE OF BIRTH)*_______

EMPLOYER ____

INSURANCE COMPANY NAME ____

ADDRESS ____

IDENTIFICATION # ________________________________ GROUP # _____________________________________

INSURANCE COMPANY PHONE # ____

WORKERS COMP INFORMATION:

INSURANCE COMPANY NAME ____

ADDRESS ____

TELEPHONE # ___________________________ CASE MANAGER NAME __________________________

CLAIM # ____