ELEVATE
PHYSICAL THERAPY

PATIENT REGISTRATION

Last Name_____ **First Name**_____ **Middle Initial** _____

Address_____**City/State**_____**Zip**_____

Phone _____**Social Security #**_____**Birth date**_____ **Sex F M**

Cell Phone_____ **E-mail Address**_____

Are you the primary insured? Yes No **Relationship to Insured:** _____

If different than patient, please provide Primary Insured name and date of birth:

Name: _____ **Date of Birth:** _____

Would you like to receive appointment reminders? ____ **Yes** ____ **No**

Please choose which method of reminder you would like: Phone Call Text Email

Marital Status: Single, Married, Divorced, Widowed **Spouse's Name** _____

Whom may we contact in case of an emergency? Name: _____

Relation: _____ **Phone:** _____

Your Employment Status: Full Time, Part Time, Retired, Unemployed, Self-employed

Your Employer_____ **Work Phone**_____

Do we have permission to contact you at work regarding your account? Yes/ No

Have you or any family member ever been treated in our office before?_____

How did you hear about Elevate Physical Therapy?_____

Is this a Worker's Compensation case or automobile accident? Yes No

What was the date of injury? _____

Have you had any PT/Home health this year?___ **If YES, Discharge date?**_____ **# Visits** _____

Parent's Name(If patient is a minor) _____ **Parents Date of Birth** _____

Responsible Party (Signing Paperwork) _____**Social Security #**_____