



REGISTRATION FORM

Please complete the following information to the best of your ability.

PATIENT INFORMATION

Name: _____ Date: _____
Date of Birth: _____ Sex: M/F Marital Status: _____
Phone #: (home) _____ (work) _____ (cell) _____
E-mail Address: _____
Address: _____
Social Security #: _____ Referring Dr.: _____

PRIMARY MEDICAL INSURANCE

Policy Holder's Name: _____ Relation to Patient: _____
Policy Holder's Soc. Sec. #: _____ Employer: _____
Policy Holder's DOB: _____ Insurance Co. Name: _____

*****Please provide us with a copy of insurance card*****

SECONDARY MEDICAL INSURANCE

Policy Holder's Name: _____ Relation to Patient: _____
Policy Holder's Soc. Sec. #: _____ Employer: _____
Policy Holder's DOB: _____ Insurance Co. Name: _____

OTHER INFORMATION

Name of Family Doctor: _____ Date last seen by Doctor: _____
Patient's next scheduled Dr.'s appointment: _____
In an accident, Date/Nature of Injury: _____
Has patient ever received therapy before? Y / N If Yes, for what? _____
If this is a legal case, the name/address of attorney: _____

Person to contact in case of emergency: _____ Relationship: _____
Phone #: _____

How did you hear about Excel Physical Therapy? _____

Why did you choose Excel Physical Therapy? _____
