Patient Registration

Name: (Last) ____ (First) _________________________ (M) ______

Birth Date: ________________ **Sex:** M F **S.S. #:** _____________________________________ **Marital Satus:** M D W S

Home Address: ___________________________________ **City:** _______________________ **State:** _____ **Zip:** _______

Home Ph:( ) _________________ **Cell Ph:**( ) ____________________ **Work Ph:**( )_________________

Reminder calls: Phone:( ) _________________ - ☐ **None** /☐ **Text** /☐ **Voice** /☐ **Email**

Email address: __________________________@_______________ : ☐ Patient Statements ☐ TheraFit Newsletter

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Emergency Contact: ☐ **Spouse / Guardian Information:** ☐ **Other Relationship:** ___________________

Name: (Last) ____ (First) _________________________ (M) ______

Home Address: ___________________________________ **City:** _______________________ **State:** _____ **Zip:** _______

Home Ph:( ) _________________ **Cell Ph:**( ) ____________________ **Work Ph:**( )_________________

Referring Physician: ____ **Phone:** _________________________________

Area being treated: ☐ **Shoulder- R / L** ☐ **Knee- R / L** ☐ **Ankle- R / L** ☐ **Hip- R / L** ☐ **LBP** ☐ **Neck** ☐ **Spine** ☐ **Other:** __________________

Have you had speech or physical therapy this year? ☐ **Yes** ☐ **No**

If yes, how many? ______ **Where?** ____

Date pain began: __________________ **Date of Injury:** _________________ **Date of Surgery:** _____________________

Accident - Auto / Sports / Fall: YES / NO - If YES, When: ____________________ **Where:** _____________________

Does patient have any of the following documents, *If so, check the box provided*: *A copy will be needed for our records

☐ **Health Care POA** ☐ **Financial POA** ☐ **DNR Status**

Primary Insurance: ____ **Policy #:** ___________________________________

Group #: _________ **Policy Holder:** ____ **Insurer's DOB:** ___________

Relationship to Patient: ☐ **Self** ☐ **Spouse** ☐ **Mother** ☐ **Father** ☐ **Other:** _________________________________

Secondary Insurance: _____________________________________ **Policy #:** ___________________________________

Group #: _________ **Policy Holder:** ____ **DOB:** ________________

Relationship to Patient: ☐ **Self** ☐ **Spouse** ☐ **Mother** ☐ **Father** ☐ **Other:** _________________________________

Auto/Workman's Comp: Company: ______________________ **Company Address:**_________________________________

Contact Person: ______________________ **Contact Ph. # : (___)** ______________ **Claim #:** _________________________

Consent for Care and Treatment

I, the undersigned do hereby agree and give my consent for TheraFit, LLC to furnish medical care and treatment to (Patient's name) ____ considered necessary and proper in treating their physical condition.

Signature: ____ Date: _____________

***(If patient is 18 or under, a Parent/Guardian's signature is required).**