Sanders Therapy Group

REGISTRATION FORM

Patient Information

Patient Name: _____ Date of birth: _____Age_____ M F

SS# _____-_____-_____ Marital Status: Married Single Divorced Widow Separated

Street Address: _____City: _____State: _____ Zip code: _____

Mailing Address: _____City: _____ State: _____ Zip code: _____

Best Phone #: _____ Alternative Phone #: _____

Email: _____

Employer Name: _____ Full time: _____ Part-time: _____ Phone #: _____

Referring Physician: _____ Phone #: _____

Primary Care Physician (if different): _____ Phone#: _____

Emergency Contact: _____Relationship: _____ Phone #: _____

Spouse/Parent Information (Fill in only if you are NOT the insurance policy holder)

Name: _____ Date of birth: _____ SS# _____-_____-_____

Address (if different): _____ City: _____ State: _____ Zip code: _____

Previous Therapy Treatment:

Have you had OT/PT therapy treatment in any other facility this year? _____

If so, where: _____ How long: _____

Accident Information:

Was this as a result of an accident/injury: YES NO If YES, date of accident: _____

Place of accident: HOME WORK CAR/AUTO OTHER (Specify): _____

Insurance Information:

Primary type of Insurance: GROUP MEDICARE WORK COMP AUTO SELF-PAY OTHER

Insurance Company: _____ Phone #: _____Insured's Name: _____

ID Number/Claim Number: _____ Group Number: _____

Is an attorney involved with this claim? YES NO If YES, name of attorney: _____

Where did you hear about us? MD FRIEND FAMILY RADIO FACEBOOK OTHER: _____

Patient/Guardian Signature **Date**