Physical Therapy & Wellness of Richmond

NEW PATIENT REGISTRATION

PATIENT INFORMATION Date________________

Patient Name: ____________________________________ SS#: ___ ___ ___-___ ___-___ ___ ___ ___
Responsible Party: ____
Street Address: ____
City: ____ State: ________ Zip: _______________
Age: __________________ Date of Birth: ________/________/________ Gender: _____M _____F
Marital Status: ________Single _______Married ______Widowed ______Divorced ______Separated

Home Phone: (________) ______________________ Cell Phone: (________) _____________________
Email: ____
Preferred Method of Contact: _____Home Phone _____Cell Phone _____Email
Would you like to receive appointment reminders? _____Email _____Text _____Both _____None

Referring Physician: ___________________________ Office Phone: (________) _________________
Primary Care Physician: _______________________ Office Phone: (________) _________________
Other Physician: _______________________________ Office Phone: (________) _________________
Referral Source (other than physician): ____
Have you been seen at another physical therapy office this year? _____YES _____NO

EMPLOYMENT INFORMATION

Employer: ______________________________________ Occupation: _________________________
Street Address: ____
City: ____ State: ________ Zip: _______________
Office Phone: (________) _______________________
Employment Status: _____Full-time _____Part-time _____Other _____Student

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM PATIENT)

Name: ____ SS#: ___ ___ ___-___ ___-___ ___ ___ ___
Date of Birth: ________/________/________
Street Address: ____
City: ____ State: ________ Zip: _______________
Home Phone: (________) _______________________ Cell Phone: (________) __________________
Employer: ____

EMERGENCY CONTACT

Name: ______________________ Relationship: _______________ Phone: (________) ____________

INSURANCE INFORMATION

Primary Insurance Carrier: ____
Name of Insured: ____
Relation to Insured: ____________________ Date of Birth of Insured: ____________
ID#: ______________________________ Group#: ________________________

Secondary Insurance Carrier: ____
ID#: ______________________________ Group#: ________________________

Accident Type: **Not Applicable**

Work Related Injury
Date of Injury: ______/______/______
Date/Time you first sought treatment: ____________________________
Employer at time of injury: ____________________________
Employer Phone: (______) ____________________________
Employer Address: ____________________________
Worker's Compensation Contact Name: ____________________________
Worker's Compensation Contact Phone: (______) ____________________
Claim is: ______Open ______Closed

Auto Accident
Date of Accident: ______/______/______
State of Accident: ____________________________
Date/Time you first sought treatment: ____________________________
Litigation Pending: ____Y ____N
Attorney's Name: ____________________________
Attorney's Phone: (______) ____________________________

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, the undersigned, hereby assign all medical benefits, including Medicare, private insurance, major medical benefits, Worker's Compensation and any other health plans to which I am entitled to Physical Therapy & Wellness of Richmond. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize Physical Therapy & Wellness of Richmond to release all medical information and records as necessary to secure payment for services rendered.

Signature ______________________________ Date ______________________
Patient/Guardian