

Patient Registration



Patient Information

Office use only

Last Name _____ First Name _____ MI _____ Nickname _____ Social Security Number _____

Chart Number

Street Address _____ Apt. # _____ Month / Day / Year _____ Weight (lbs.) _____
(Birthdate)

City _____ State _____ Zip Code _____ Month / Day / Year _____
(New Patient Date) Male Female

Home Phone _____ Email Address _____

Cell Phone _____ Relationship to Primary Insurance Holder _____

Work Phone _____ Relationship to Secondary Insurance Holder _____

Employment Type (Check One Box)	
<input type="checkbox"/> Full Time Student	<input type="checkbox"/> Self Employed
<input type="checkbox"/> Part Time Student	<input type="checkbox"/> Retired
<input type="checkbox"/> Employed	<input type="checkbox"/> Active Military
<input type="checkbox"/> Not Employed	<input type="checkbox"/> Unknown

Marital Status (Check One Box)	
<input type="checkbox"/> Single	<input type="checkbox"/> Widowed
<input type="checkbox"/> Married	<input type="checkbox"/> Unknown
<input type="checkbox"/> Legally Separated	<input type="checkbox"/> Partner

Office use only
<u>Mark Netzinger</u> Provider
<u>Physical Therapy Consultants</u> Office
<u>Initial Fee Schedule</u> Fee Schedule

Diagnosis _____ Diagnosis Codes _____

Referring Physician Information

Last Name _____ First Name _____ Title _____ Suffix _____

Office/Company _____ Dept. _____

Street Address _____ Suite _____

City _____ State _____ Zip Code _____

Phone Number _____

Fax Number _____

Referral Type _____ Specialty _____

Primary Care Physician Information

Last Name _____ First Name _____ Title _____ Suffix _____

Office/Company _____ Dept. _____

Street Address _____ Suite _____

City _____ State _____ Zip Code _____

Phone Number _____

Fax Number _____

Referral Type _____ Specialty _____

Emergency Contact Information

Last Name _____ First Name _____ Phone Number _____ Relationship to the Patient _____



Primary Insurance Information

Last Name (guarantor)	First Name	Middle Initial	Nickname	Social Security Number
Street Address			Apt. #	Month / Day / Year (Birthdate)
City		State	Zip Code	<input type="checkbox"/> Male
Home Phone	Email Address			<input type="checkbox"/> Female
Cell Phone	<input type="checkbox"/> Auto Liability	Month / Day / Year (Injury Date)	Claim Number	Policy Number
Work Phone	<input type="checkbox"/> Workers Comp.	Adjustor's Name	Adjustor's Phone Number	

Employer Name	Phone Number
Street Address	Ste. # City State Zip

Insurance Carrier's Name	Subscriber Number (ID Number)	Group Number
Street Address	Ste. # City State Zip	

Secondary Insurance Information

Last Name (guarantor)	First Name	Middle Initial	Nickname	Social Security Number
Street Address			Apt. #	Month / Day / Year (Birthdate)
City		State	Zip Code	<input type="checkbox"/> Male
Home Phone	Email Address			<input type="checkbox"/> Female
Cell Phone	<input type="checkbox"/> Auto Liability	Month / Day / Year (Injury Date)	Claim Number	Policy Number
Work Phone	<input type="checkbox"/> Workers Comp.	Adjustor's Name	Adjustor's Phone Number	

Employer Name	Phone Number
Street Address	Ste. # City State Zip

Insurance Carrier's Name	Subscriber Number (ID Number)	Group Number
Street Address	Ste. # City State Zip	

How did you hear about us? _____

Patient Signature

Date