

PHYSICAL THERAPY AT DAWN
REGISTRATION FORM
Please Print

First Name _____ M.I. _____ Last Name _____

Street Address _____ Apt # _____

City _____ State _____ Zip code _____

Home Phone # _____ Cell Phone # _____

Social Security # _____ Marital Status _____

Date of Birth _____ Occupation _____

Referral source Dr. _____ Insurance Co. Family member
 Friend Close to work/home Internet Yellow pages
 Other _____

Who is your Primary Care Doctor? _____

What happened? Please tell us a little bit about what brought you here!

What are we treating you for? _____ Date of Injury _____

Accident related to: Work: Yes No Auto Accident: Yes No Other: _____

Date of next visit with referring Doctor: _____

Insurance Information: Please provide your insurance card for us to make a copy of.

Primary Insurance Company Name: _____

ID Number (located on insurance card): _____ Group number: _____

If Medicare is your Primary Insurance, please answer the following questions:

Have you received Physical or Speech Therapy in this calendar year? Yes No

If yes, what date(s) and where? _____

If yes, was that therapy for the same injury? _____

Are you currently receiving Home Health Care for any condition? Yes No

In case of emergency, please contact: _____ Phone # _____

The above information is true to the best of my knowledge. I also authorize Physical Therapy at Dawn to release any information required to process my claims.

Patient/Guardian Signature

Date