**For Office Use Only:** Acct #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Start/Restart Date;\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RX Date\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SS#**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**\_\_\_\_/\_\_\_\_/\_\_\_\_

 First Last MM/DD/YR

**Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex M F Age\_\_\_\_\_\_ Marital Status S M

 Street/PO Box (Circle one) (Circle one)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City State Zip **Employer**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone** ( )\_\_\_\_\_\_\_\_\_\_\_\_Cell ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Address:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street/ PO Box

**Work Phone** ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City State Zip

**Parent/Spouse Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address** (if different)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Emergency Contact\***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street Apt #

 Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City State Zip

**Referring Physician:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date Last seen by Physician:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Being seen today;\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Body Part:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_L /R

**Motor Vehicle Accident:**  Yes No **State of accident:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Accident:**\_\_\_\_\_\_\_\_\_\_\_

**Work Related:** Yes No **Cause of Injury:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Injury:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you received Home Heath Care**  OR **Physical Therapy in the last year?** Yes No (Circle one)

Number of Visits used for home health care\_\_\_\_\_\_\_\_\_\_\_\_ Number of previous PT visits\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent for Treatment.**

 I hereby give my consent to receive treatment by a rehabilitation provider.

**Authorization to Release Payment and Information.** I request that payment authorized insurance benefits be made either to me or on my behalf to CORE Physical Therapy PC, for any series furnished to me by a rehabilitation provider at this facility. I authorize any holding of medical information about me to be released to my insurance carrier and its agents for information needed to determine these benefits or the benefits payable for related services. **Our Payment Policy.** As a service to you all insurances will be billed by our office. However, your are responsible to use for the payment of you balance Payments can be made at any time to our office, by mail, or phone. IF you do not have any insurance, payment will be expected at time of services unless otherwise arranged by C.O.R.E.

**Signature:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (if under 18 or under, parent or guardian must sign this patient registration form on your behalf)