Patient Registration Form

Name: _____
First **Middle** **Last** **Suffix**

Date of Birth: _____ Social Security #: _____ (*Required for Medicare, WC, MVA*)

Gender: □ Male □ Female

Mailing Address:_____
Street Apt. City State Zip

Primary Phone: (____) _____ Type (H) (W) (C) Secondary Phone: (____) _____ Type (H) (W) (C)

Email: _____ Appointment Reminders will be set to your choice:

Call or Text Options: □ Call □ Text □ Primary or □ Secondary Phone Opt out instead □ Yes □ No

How did you hear about Elite? □ My Doctor □ Elite Staff □ Event Promotion □Family/Friend

□Google Search □ Gym Membership □ Mailing Ad □ Online Ad □ Other: _____

Emergency Contact: _____ Phone: (____) _____ Relationship: _____

Diagnosis (or body part to be treated): _____ □ Left □ Right □ Bilateral

Referring Physician Name: _____**Is my Primary Care Physician** □ Yes □ No

Primary Care Physician (PCP): _____ Office location:_____

Is this the same PCP on file with your Health Insurance Carrier? □ Yes □ No*

***If No**, please update your assigned PCP immediately by calling Member Services on the back of your insurance card.*

Have you treated at any Physical Therapy facility in the current year? □ Yes- *Visits may affect insurance limits* □ No
Is this injury related to an accident? □ Yes - *Please see Section A.* □ No- *Please* see *Section B.*
Section (A.)

Accident Type: □ Work □ Auto □ Slip/Fall □ Other _____
Date of Injury: _____ Report filed with: □ Employer □ Auto Insurance □ Property Insurance □None
Accident occurred in: □ Rhode Island □ Massachusetts □ Other _____

Do you have an attorney representing your claim? □ Yes- **Please see Lien Form* □ No □ Pending
Attorney: _____ Law Firm: _____ Phone: (___) _____

Has Worker's Compensation accepted your claim? □ Yes □ No-**Pre-Authorization is required for all WC*
Claim Number: _____ Insurance Name: _____
Adjuster Name: _____ Phone: (___) _____ Fax: (___)_____
Employer Name: _____ Contact: _____ Phone: (____) _____
Address: _____
Street City State Zip
Has an Auto Insurance Claim been opened to accept your medical bills?
Yes: □ Med Pay/RI □ PIP/MA **No:** □ Pending □ Not pursuing claim

Policy Type: □ *My Own policy □ *Other Party Policy □ *Third Party Policy **Please see Lien Form*
Claim Number: _____ Insurance Name: _____
Adjuster Name: _____ Phone: (___) _____ Fax: (___) _____

Section (B.)

Primary Insurance Name: _____Subscriber ID#: _____
Group/Policy #: _____ **Are you the subscriber?** □ Yes □ No
Subscriber Name: _____ Date of Birth: _____ Relationship: _____
Address on file:_____
Street City State Zip

Secondary Insurance Name: _____ Subscriber ID#: _____
Group/Policy #: _____ **Are you the subscriber?** □ Yes □ No
Subscriber Name: _____ Date of Birth: _____ Relationship: _____
Address on file:_____
Street City State Zip

Tertiary Insurance Name: _____Subscriber ID#: _____
Group/Policy #: _____ **Are you the subscriber?** □ Yes □ No
Subscriber Name: _____ Date of Birth: _____ Relationship: _____
Address on file: _____
Street City State Zip
Is this related to a recent surgery? □Yes - Surgical Date: _____ □ No
Did you receive any Home Healthcare Services? □ Yes -**Please see Medicare Questionnaire* □ No
Have you been discharged from Home Healthcare? □Yes - Date of Discharge: _____ □ No
If you are a Medicare beneficiary, outpatient therapy will need to be postponed until after all Home Healthcare Services have been discharged per Medicare Regulations.

Please present all medical insurance cards and a photo ID to the front desk staff and advise if these are not the most current copy or you are expecting to receive newer cards in the near future. We are required to retain photocopies of these in your medical record for health insurance fraud regulation requirements. Thank you for your cooperation!

_____ _____
Patient/Guardian Signature Date