



Patient Registration Form

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

Date of Birth: _____ Social Security #: _____ (Required for WC, MVA, Tricare and TriWest)

Gender: Male Female

Mailing Address: _____
 Street Apt. City State Zip

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

Email: _____

Reminder Call Options: Primary or Secondary Phone

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

Self Google Search 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 related to a recent surgery? Yes No Surgical Date: _____

Is this injury related to an accident? Yes No (If yes, complete form for accident type)

Accident Type: Work Auto Slip/Fall Other _____

Do you have an HRA or HSA Account? Yes No

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/HRA/HSA Information:
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

Have you received 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 if you are expecting to receive newer cards soon. We are required to retain photocopies of these in your medical record for health insurance fraud regulations. Thank you for your cooperation!

Patient/Guardian Signature

Date