

Patient Registration

BACK TO ACTION
PHYSICAL THERAPY
PLC

Waitsfield Vermont

PATIENT INFORMATION FORM

1. Personal Information.

Name _____ Date _____

Mailing Address _____

Town _____ State _____ Zip _____

Residential Address (if different) _____

Town _____ State _____ Zip _____

Phone Numbers: Home _____ Work _____ Cell _____

Social Security Number _____ M ____ F ____ Date of Birth _____

Primary Care Physician _____ Referring Physician _____

Emergency Contact _____ Relationship _____ Phone _____

If we need to contact you, and there is no answer, do we have permission to leave a message stating Back to Action PT called (circle one)? Yes No

Is it okay for us to contact your insurance company prior to your visit to get authorization, if needed (circle one)? Yes No

2. Important Information.

1. Is your diagnosis related to (please circle correct answer)
A work injury (In which a Worker's Compensation claim has been filed) Yes (fill in below) No
Motor vehicle accident Yes (fill in below) No
Accident related to any insurance other than health insurance below Yes (fill in below) No
If Yes, please provide claim number and name of carrier covering claim _____

3. Insurance Billing Information.

Please provide all insurance card(s) at time of first visit.

Bill to:

Health Insurance: _____ Automobile Insurance _____ Workers Compensation _____ Self Pay _____
(Payment due at time of visit for self-pay patients)

Name of Insurance Company _____

Name of Subscriber _____ (Person holding policy other than self)

Relation: Self ____ Spouse ____ Parent ____ Other ____ Subscriber's Date of Birth _____

Secondary Insurance (if applicable): Please provide us with your secondary insurance card.

How did you hear about Back To Action Physical Therapy?

Doctor ____ Friend ____ Newspaper Ad ____ Vermont Sports ____ MadRiver TV ____ Other : _____