PALMETTO REHAB
PHYSICAL THERAPY

## PATIENT REGISTRATION

**Date: ____ /____ /____**

| | | | |
|---|---|---|---|
| NAME (LAST, FIRST, MIDDLE) | | | PREFERRED NAME |
| ADDRESS (STREET, APT#) | CITY, STATE | | ZIP CODE |
| HOME PHONE | WORK PHONE | CELL PHONE | |
| SSN | SEX | EMAIL ADDRESS | DATE OF BIRTH / / |
| DATE OF INJURY / ONSET OF PROBLEM / / | ACCIDENT / INJURY OCCURRED ___ WORK ____SCHOOL ___AUTO ___OTHER (PLEASE LIST BELOW) _____ | | |
| MARITAL STATUS ___SINGLE ___MARRIED ___DIVORCED ___WIDOWED ___SEPARATED ___OTHER | WORK STATUS ___EMPLOYED ___UNEMPLOYED ___STUDENT ___RETIRED ___OTHER | | |
| EMERGENCY CONTACT | PHONE NUMBER | RELATIONSHIP | |
| REFERRING PHYSICIAN | PRACTICE NAME | PHONE NUMBER | |

### RESPONSIBLE PARTY INSURANCE INFORMATION

| | | |
|---|---|---|
| PRIMARY INSURANCE | POLICY / ID NUMBER | GROUP NUMBER |
| POLICYHOLDER NAME (LAST, FIRST, MIDDLE) | | RELATIONSHIP TO INSURED |
| SSN | DATE OF BIRTH / / | |
| SECONDARY INSURANCE | POLICY / ID NUMBER | GROUP NUMBER |
| POLICYHOLDER NAME (LAST, FIRST, MIDDLE) | | RELATIONSHIP TO INSURED |

| | | |
|---|---|---|
| EMPLOYER | EMPLOYER ADDRESS | EMPLOYER PHONE |
| ADJUSTOR NAME | PHONE NUMBER | CLAIM NUMBER |

I certify that this information is true and correct to the best of my knowledge. If there any changes to any of this information it is my responsibility to inform Palmetto Rehabilitation Specialist.

Signature of Person Financially Responsible Date Accepted By