



Registration Form

Copper Ridge Marketplace, 4000 Eastern Sky Dr., Suite 6
Phone: 231.932.9014 Fax: 231.932.9034

Today's Date _____ Preliminary Diagnosis _____

Last Name _____ First Name _____ Middle Initial _____

Home Phone _____ Work Phone _____ Cell Phone _____

(Please circle the phone number which is best to reach you during the day).

Home Address _____ City _____

State _____ Zip _____ Social Security # _____ Date of Birth _____

E-Mail Address: _____ Male or Female (circle)

Chose clinic because/Referred to clinic by (please Circle answer): Physician, Family member, Friend, Insurance Co.,
Other _____

Have you received Physical, Occupational, or Speech therapy services in the current calendar year? ____ Yes ____ No

If yes, where? _____ Phone _____

Start Date _____ End Date _____

Are you currently receiving home health services? ____ Yes ____ No

Employer Name _____

Spouse's Name _____ Work Phone _____

Emergency Contact _____ Relationship _____ Phone _____

Family Physician (PCP) _____

Financial Information (If patient is a minor, please complete this section)

Name of Responsible Party _____ Relationship _____

Address _____ Phone _____

Basic Workman's Comp./Auto Insurance/Injury Information (Please complete if injury is work or auto related.)

Date of Injury (or onset of pain): _____

Type of Accident: Job: _____ Contact Person: _____

Auto: _____ Claim #: _____

Contact Person: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Accelerated Mobility Physical Therapy, LLC. I understand that I am financially responsible for any balance. I authorize Accelerated Mobility Physical Therapy, LLC or insurance company to release any information required to process my claims.

Patient/Guardian signature _____ Date _____

Office Use Only:

Referring Physician _____ Phone _____

Diagnosis _____ Dx Code(s) _____

Date of Onset _____ Date of Evaluation _____