

MALETTA PFEIFFER & ASSOCIATES

PATIENT REGISTRATION FORM

Patient's Name: _____ Address: _____

_____ City, State, Zip _____

Date of Birth _____ Home Phone: _____ Cell Phone: _____

E-Mail Address: _____

Are you currently in the military? Yes _____ No _____ Please initial _____

Single _____ Married _____ Widowed _____ Divorced _____

Social Security #: _____ Employer: _____

Employer Address: _____ Business Phone: _____

Occupation: _____

May we leave a message for you regarding physical therapy appointments

At your home: seY ف oN ف

At work: ف Yes rehtO oN ف

To date this year, have you received any:

Physical Therapy____, Occupational Therapy____, Chiropractic care____, Speech____?

Presently are you receiving any services from a Visiting Nurse Agency? Yes___No__

Referring Physician: _____

How did you hear about our services?

Phonebook:____ Internet:____ Doctor:____ Friend:____ Relative:____

Newsletter:____ Other: _____

Spouse, Parent, Relative Information

Name: _____ Relation: _____

Phone: _____

Insurance Coverage

Insured Name: _____

Name of Ins. Co.: _____

Workers Compensation

Please complete this section only if job related injury.

Date of Injury:_____.

Did you file a claim with your employer? Yes () No (). Have they accepted responsibility for your medical bills? Yes () No (). Who was your employer at the

time of injury:_____ Address:_____

City, State, Zip:_____. Responsible person:_____

Claim #:_____ Phone:_____ Ins. Co. #:_____.

No Fault Claim

Complete this section if automobile-related injury.

Did you file a no-fault claim form? Yes () No (). Date of Accident:_____

Town of Accident:_____ Insureds Name:_____

Policy #:_____ Claim #:_____ Ins. Co._____

Address:_____ City, State, Zip:_____

Phone:_____ What is the limit of policy coverage? \$_____.

What dollar amount has been used to date? \$_____.

Attorney's name:_____.

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

_____ Date_____

Please sign (Insured or authorized person)