

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

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 : _____