

**HEALY PHYSICAL THERAPY & SPORTS MEDICINE, INC.**

927B WARREN AVE., EAST PROVIDENCE, RI 02914

info@401getwell.com

**REGISTRATION FORM****Today's Date:****Primary Care Physician:****PATIENT INFORMATION**

Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status: Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>	
If under 18, parent/guardian responsible:	Social Security no.:		Birth date:	Age:	Sex: <input type="checkbox"/> F <input type="checkbox"/> M	Date of Injury:	
Street address:			Home phone no.: ( )		Cell phone no.: ( )		
City:	State:	ZIP Code	Occupation:				
Employer:	Work Status: FT <input type="checkbox"/> PT <input type="checkbox"/> Diem <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Other _____			Employer phone no.: ( )			
Chose clinic because/referred to clinic by (Please check one box):				<input type="checkbox"/> Dr	<input type="checkbox"/> Insurance plan	<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other			
Other family members seen here:				Have you been previously treated here: No <input type="checkbox"/> Yes <input type="checkbox"/> when: _____			

**INSURANCE INFORMATION**

(Please give your insurance card and a picture ID to the receptionist.)

Name of primary insurance/Group no.:		Subscriber's name:		Birth Date:	Home phone no.: ( )		
Occupation:	Employer:	Employer address:			Employer phone no.: ( )		
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other			
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:		
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other			
<b>Motor Vehicle Accident:</b> No <input type="checkbox"/> Yes <input type="checkbox"/> Date:				<b>Work Related Injury:</b> No <input type="checkbox"/> Yes <input type="checkbox"/> Date:			
Attorney/Insurance Name:		Address:			Contact phone no.: ( )		

**IN CASE OF EMERGENCY**

Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Healy Physical Therapy & Sports Medicine, Inc. I understand that I am financially responsible for any balance. I also authorize Healy Physical Therapy & Sports Medicine, Inc. or insurance company to release any information required to process my claims.

**Patient/Guardian signature****Date**