Dubuque Physical Therapy Registration Form Date: _____

Name: _____
First MI Last

Address: _____
Number Street City State Zip

Permanent Address (if different from above): _____

Home Phone: _____ Age _____ Date of Birth: _____ Social Security #: _____

Employer Name: _____ Work Phone: _____

Employer Address: _____
Number Street City State Zip

PLEASE CHECK: □ Single □ Married □ Divorced □ Widowed Sex: □ Male □ Female

Spouses Name: _____ Date of Birth: _____ Social Security #_____

Spouses Employer Name: _____Work Phone: _____

Spouses Employer Address: _____
Number Street City State Zip

Emergency Contact (If different from spouse): _____ Phone #: _____

Please give us all information regarding your insurance plan(s). Please show all numbers on your card(s). IF YOUR BENEFITS DEPEND ON PRE-AUTHORIZATION, IT IS YOUR RESPONSIBILITY TO INFORM US, UNLESS WE ARE A PROVIDER FOR YOUR PLAN(S).

PRIMARY	Plan Name:	Name on Insurance Card
	PATIENTS RELATIONSHIP TO POLICY HOLDER □ Self □ Spouse □ Child □ Other	Insured SSN# Insured Date of Birth
	Insured ID No: Group No:	Insured Address (if different from patient)
	Insured Employer Employer Phone#	Insured Phone# (if different from patient)

SECONDARY	Plan Name:	Name on Insurance Card
	PATIENTS RELATIONSHIP TO POLICY HOLDER □ Self □ Spouse □ Child □ Other	Insured SSN# Insured Date of Birth
	Insured ID No: Group No:	Insured Address (if different from patient)
	Insured Employer Employer Phone#	Insured Phone# (if different from patient)

WORK COMP INFORMATION

Was this an on-the-job injury? □ Yes □ No If yes, have you notified the employer? □ Yes □ No

DATE OF INJURY: _____ Employer Name: _____ Employer Contact: _____

ACCIDENT INFORMATION

Accident Type: □ Auto □ Other _____ Accident Date: _____Claim #:_____