Patient Registration Information

Date:

Please PRINT and complete ALL sections below!

Co-Pay:

Is your condition a result of a work injury? YES NO

Have you had physical therapy with us? YES NO

An automobile accident? YES NO

If so, when and what for?

Date of onset/injury:

Are you an employee of SRMC?

Are you a member of Senior Circle?

Patient's Personal Information

Name:
(First) (Middle) (Last)

Date of Birth:

Social Security #:

Mailing Address:

City: State: Zip Code:

Street Address:

City: State: Zip Code:
(If different from mailing address)

Home Phone: Cell Phone: Work Phone:

Sex: Male Female

Social Security Number:
Please circle one.

Marital Status: Single Married Separated Divorced Widow/Widower
Please circle one.

Race: Primary Language: Religion:

Employer: ☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployeed ☐ Self

Employer Address:

City: State: Zip Code:

Your Occupation:

Spouse/Parent (if minor) Information

Please complete spouse information if insurance is under spouse.

Spouse/Parent Name:

Spouse/Parent Social Security #:

Spouse/Parent Employer Address:

City: State: Zip Code:

Spouse/Parent Date of Birth:

Spouse/Parent Occupation:

Spouse/Parent Work Phone:

Spouse/Parent Employer:

Accident/Injury Information

Is the injury a fault of someone else? YES NO

Name of attorney if one is handling injury claim:

Name of person at fault:

Name of their insurance:

Policy number:

Insurance phone number:

Insurance address, if known:

If not, name of your auto/home owners insurance:

Policy #:

Phone number:

Address (if known)

Physician Information

Referring Physician:

Phone:

Primary Care Physician:

Phone:

Emergency Contact

Please provide 2 emergency contacts, one not living with you.

Name:

Relationship:

Address:

City: State: Zip Code:

Home Phone: Cell Phone: Work Phone:

Name:

Relationship:

Address:

City: State: Zip Code:

Home Phone: Cell Phone: Work Phone:

Medical Secondary Payor Questionnaire

Name: _____

Date: _____

1. Are you entitled to Black Lung Medical Benefits? YES NO

2. Do you get benefits from the Department of Veterans Affairs due to a service related injury? YES NO

3. Is this a work-related injury or illness? YES NO

4. Is this injury/illness related to an automobile accident or an illness or injury for which another party could be held responsible? YES NO

5. Are you currently working? YES NO

   Are you full-time, part-time or retired? _____

   If retired, what was your retirement date? _____

6. Are you currently receiving disability? YES NO

   Date of disability: _____

7. Do you have End-Stage Kidney Disease? YES NO

8. Are any of your physical therapy services to be paid for by a program such as a Research Grant? YES NO

9. If you are married, is your spouse currently working? YES NO

   If yes, are they full-time, part-time or retired? _____

   If no, what was your retirement date? _____

10. If your spouse is employeed, are you covered under that employers insurance plan? YES NO

    If yes, what is the name of the plan? _____

    Is the plan Secondary to Medicare? _____

Please READ and SIGN the following

Insurance

Although we call the insurance companies for extension of visits and other information needed, we recommend that you, the patient and insurance carrier, call and verify co-payment amounts, policy coverage, providers and any limitations the policy might have. All co-payments are due at the time of your visit. If you have any billing questions, please contact the billing department at 804.765.5700.

Cancellation Policy

Patients who need to cancel therapy appointments should call 24 hours in advance. Failure to give notice of cancellation PRIOR TO the scheduled appopintment time is considered a NO SHOW. Any patient that misses (2) consecutive appointments or repeatedly cancels will be removed from the schedule and then required to schedule on a day-to-day basis. Any patient that misses (3) consecutive appointments will be discharged and referred back to their physician. If your therapy needs to be put on hold, please speak with your therapist. Remember, in order for you to make progress, you need to attend therapy. If you have any questions, please feel free to ask.

Thank you for your cooperation.
Southside Regional Rehabilitation

Signature of Patient/Legal Guardian: _____

Date: _____