EMORY CLINIC
Physical Therapy

REGISTRATION FORM

Please help us serve you better by taking a few minutes to provide the following information
(Please Print)

Welcome to our Rehabilitation Department. We would like for your experience to be an enjoyable one. Your physician has prescribed a series of therapy treatments that are medically necessary for you to get the maximum benefit from your rehabilitation program. If you are unable to keep this appointment, kindly give 24 hour notice so that we may continue to accommodate all of our patients.

PATIENT INFORMATION

Social Security Number	Last Name	First Name	MI	Date:

Address	Zip Code	City	State	Home Telephone Number

Date of Birth	Sex (Circle one) Male or Female	If minor name of parent or guardian

Martial Status (Circle One) Married Divorced Single Widowed Separated	Employment Status (Circle One) Retired Full Part None Student (Circle One) Full Part None	Email Address	Relationship to Insured (Circle One) Child Self Spouse Other

Employer	Position

Address	Zip Code	City	State	Employer's Phone Number

RESPONSIBLE PARTY (If Patient is responsible party, skip this section)

Employed (Circle) Yes No	Last Name	First Name	MI

Address	Zip Code	City	State

Relationship to Insured (Circle One) Child Self Spouse Other	Social Security Number	Date of Birth

Employer	Position	Business Phone Number/CellPhone #

INSURANCE INFORMATION

Primary Insurance Company	Policy # :	Name of Insured
	Group #:	Social Security #:
Address:	ID #	Date of Birth:

Secondary Insurance Company	Policy #:	Name of Insured
	Group #:	Social Security #:
Address:	ID # :	Date of Birth:

Employer:	Relationship to Insured (Circle One) Child Self Spouse Other

EMERGENCY INFORMATION

Person to contact in case of Emergency	Relationship	Phone Number to Contact	

Address	City	State	Zip

INJURY INFORMATION

Job Related: Yes No	Circle One: Injury Illness	Was this due to an Auto Accident: Yes No
Date of First Symptom or Accident		If Job Related Phone # to Verify or Name of Person to Contact
If Job Related Name of Employer at Time of Accident		How did Injury Occur
Where did Injury Occur		Area of Injury Symptom
If Auto Accident, name and phone number of Auto Insurance Carrier		
Claim #		State in which injury occurred

I authorize the release of appointment or account information left on the home voicemail and to:

Cell Phone Number Work Phone Number Name of Person and Relationship