PATIENT REGISTRATION FORM

Specialized PHYSICAL THERAPY
www.SpecializedNJ.com
(201) 773-8851

Fields marked with an (*) are optional.

Patient Information

Last Name: _____ First Name: _____ Middle: _____

Address: _____ City: _____ State: _____ Zip: _____

*Social Security Number: _____ DOB: (mm/dd/yyyy) _____

Are you involved in a Lawsuit? ☐ Yes ☐ No

Age: _____ Sex: ☐ M ☐ F

Marital Status: ☐ S ☐ M ☐ W ☐ D

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-Mail Address: _____

Preferred Method of Contact: ☐ Home ☐ Work ☐ Cell ☐ E-Mail

Emergency Contact: _____ Relationship: _____ Phone Number: _____

Occupation: _____ Employer: _____ Employer Phone Number: _____

Insurance Information

Primary Insurance Company: _____ Insured's Name: _____ Date of Birth: _____

Relationship to Patient: _____ Policy Number: _____ Insured's Employer: _____

Secondary Insurance Company: _____ Insured's Name: _____ Date of Birth: _____

Relationship to Patient: _____ Policy Number: _____ Insured's Employer: _____

Physician Information

Referring Physician: _____ Referring Physician Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

How Did You Find Out About Specialized Physical Therapy

☐ I am a Former Patient ☐ Clinic Sign ☐ Yelp ☐ Google

☐ Workers Comp./ Case Manager ☐ Doctor Recommendation ☐ Insurance Co. Recommendation ☐ Facebook

☐ Family/Friend Recommendation Name: _____ ☐ Other: _____

Photo ID, insurance card, and co-pay are required on day of visit. If you did not bring insurance cards with you, all charges will be your responsibility and payable at time of service. Obtaining required referral forms and treatment precertification is the patient's responsibility. ALL UNPAID BALANCES AND/OR DENIED CLAIMS ARE YOUR RESPONSIBILITY

PRINT > **FILL OUT** > **FAX** **To 201-773-8853 & bring to your appointment.**