Outpatient Rehabilitation Services
Patient Registration

ADVANCED Regional Therapy

Patient Demographics

Today's Date:_____

Full Name:_____
Last First Initial

Current Address:_____
Street City State ZIP

Home Phone:_____ Work Phone:_____

Date of Birth:_____ Sex: ____Male ____Female Marital Status: ____M ____S ____W ____D

Social Security Number:_____ Drug Allergies:_____

Referring Physician:_____ Phone:_____

Emergency Contact:_____ Relationship:_____ Phone:_____

Financial Information

Please check available payment sources:

[ ] Health Insurance [ ] Medicare [ ] Medicaid [ ] Worker's Compensation [ ] VA [ ] Self Pay

Health Insurance
Insured Name:_____
Number:_____
Patient's Ins. ID:_____
Relationship of Patient to Insured:_____
Name of Ins. Co._____
Ins. Co. Address:_____
Ins. Co. Phone:_____

Medicare
Medicare Number:_____
Part B Benefits? [ ]Yes [ ]No Effective Date:_____

Medicaid
Medicaid Number:_____

Worker's Compensation
Claim Number:_____
Date of Injury:_____
MCO Name:_____
MCO Address:_____
Caseworker Name:_____
Caseworker Phone:_____

Please answer the following questions:

What type of therapy did your physician recommend [ ] Physical [ ] Occupational [ ] Speech
Do you have a prescription (order) from your physician? [ ] Yes [ ] No
What is the location of the illness or injury?_____
May Advanced Regional Therapy discuss your medical condition with your designated emergency contact person listed above? [ ] Yes [ ] No
Do you feel you need assistance from social services? (i.e. mental health, physical abuse, transportation, etc.) [ ] Yes [ ] No
Is this illness or injury the result of a motor vehicle accident? [ ] Yes [ ] No
Is this illness or injury employment related? [ ] Yes [ ] No
Do you feel another party is responsible for this illness or injury? [ ] Yes [ ] No
If yes, is there a claim currently in litigation? [ ] Yes [ ] No
Is the patient a member of any group health insurance plan or HMO? [ ] Yes [ ] No
If yes, what is the name of the plan?_____
Is the patient 65 years or older? [ ] Yes [ ] No
If yes, is the patient and/or spouse currently employed? [ ] Yes [ ] No
Name of Employer_____
Address of Employer_____
Has the patient been admitted to a hospital within the past 180 days? [ ] Yes [ ] No
If yes, Where_____
Approximate Dates of Confinement_____
Has the patient received any home health services in the last 90 days? [ ] Yes [ ] No
If yes, Name of Agency_____
Has the patient received any outpatient therapy services within the last calendar year? [ ] Yes [ ] No
If yes, Where_____