**OCONEE PHYSICAL THERAPY AND SPORTS REHABILITATION, INC.**

**PATIENT REGISTRATION FORM**

DATE_____ THERAPIST_____

PATIENT NAME (FIRST)_____ (MI)_____ (LAST)_____

ADDRESS_____CITY_____ZIP_____

HOME PHONE_____ WORK PHONE_____ CELL PHONE_____

DATE OF BIRTH_____/_____/_____ AGE_____ SOCIAL SECURITY # _____

SEX: Male____ Female____ MARITAL STATUS: Single _____ Married_____ Divorced _____ Widowed_____

CURRENT EMPLOYER_____

BUSINESS ADDRESS_____CITY _____ZIP_____

OCCUPATION_____ IF RETIRED, DATE OF RETIREMENT_____/_____/_____

SPOUSE'S NAME_____ WORK PHONE_____

---

**IF PATIENT IS 18 YEARS OF AGE OR UNDER OR IS A FULL-TIME STUDENT, PLEASE COMPLETE**:

FATHER'S NAME:_____ SSN_____ CELL PHONE_____

EMPLOYER_____ WORK PHONE_____

IF ADDRESS IS SAME AS ABOVE PLEASE CHECK _____ IF DIFFERENT PLEASE FILL OUT.

ADDRESS_____ CITY_____ZIP_____ PHONE _____

MOTHER'S NAME:_____ SSN_____ CELL PHONE_____

EMPLOYER_____ WORK PHONE_____

IF ADDRESS IS SAME AS ABOVE PLEASE CHECK _____ IF DIFFERENT PLEASE FILL OUT.

ADDRESS_____ CITY_____ ZIP_____ PHONE _____

---

PHYSICIAN WHO SENT YOU_____

PRESENT COMPLAINT_____

DATE OF INJURY_____/_____/_____ AND/OR DATE OF SURGERY_____/_____/_____

WAS THIS RELATED TO: AUTO ACCIDENT_____ SPORTS_____OTHER_____

IF SPORTS RELATED, NAME OF SPORT_____NAME OF SCHOOL_____

---

**PRIMARY INSURANCE**_____

POLICY HOLDERS NAME_____ DATE OF BIRTH_____/_____/_____

SSN_____ POLICY/ID #_____ GROUP #_____

**SECONDARY INSURANCE**_____

POLICY HOLDERS NAME_____ DATE OF BIRTH_____/_____/_____

SSN_____ POLICY/ID #_____ GROUP #_____

**PLEASE SELECT ONE OF THE FOLLOWING PAYMENT OPTIONS:**

_____SELF-PAY – PAYMENT IN FULL AT EACH VISIT

_____HEALTH INSURANCE – PAYMENT OF UNMET DEDUCTIBLE AND PATIENT CO-PAY OR % EACH VISIT

_____* AUTO

_____* WORKERS COMPENSATION: CLAIMS FILED WITH (EMPLOYER NAME)_____

*FOR WORKERS COMPENSATION OR AUTO LIABILITY CASES, WE ALSO NEED YOUR HEALTH INSURANCE

***IF YOU INDICATED AN AUTO ACCIDENT, PLEASE COMPLETE THE FOLLOWING:**

NAME OF PARTY AT FAULT:_____

HAVE YOU RETAINED AN ATTORNEY? YES_____ NO_____ IF YES, NAME_____

ADDRESS_____CITY_____ ZIP_____ PHONE_____

---

**AUTHORIZATION OF TREATMENT, ASSIGNMENT OF BENEFITS, AND RESPONSIBILITY**

I authorize the medical treatment, which has been or will be provided to me or my dependant, as named above, by OCONEE PHYSICAL THERAPY AND SPORTS REHABILITATION, INC., and that I am the responsible party for any such charges incurred. Should I elect to have OCONEE PHYSICAL THERAPY AND SPORTS REHABILITATION, INC., file my insurance as a courtesy. I represent that I presently maintain medical insurance coverage, which will reimburse the charges for the care provided. If my medical insurance coverage is not sufficient to satisfy these charges in full, I acknowledge that the resulting balance is not covered by this assignment and I will be fully responsible for payment of this balance at the established rates of OCONEE PHYSICAL THERAPY AND SPORTS REHABILITATION, INC.. I authorize the creditor to make a credit investigation, including employment verification, should this be necessary. I agree to be responsible for any reasonable collection costs and/or attorney's fees incurred in the collection of this account should it become delinquent. In consideration of medical services rendered by OCONEE PHYSICAL THERAPY AND SPORTS REHABILITATION, INC., I hereby assign, transfer, and set over to OCONEE PHYSICAL THERAPY AND SPORTS REHABILITATION, INC., all of my rights, title, and interest to medical reimbursement. I also authorize the release of any medical and/or billing information necessary to process claims.

_____ _____

(Signature of Responsible Party – Must be 18 or older) (Date)

_____ _____

(Signature of Policy Holder) (Signature of Witness)