Total Health & Rehabilitation **PATIENT REGISTRATION** Today's Date _____/_____/_____

First Name_____ **MI**_____ **Last**_____ **Age**_____

Street Address_____ **Apt#**_____

City _____ **State**_____ **Zip Code**_____ **Gender** M / F Other_____

Birth Date _____/_____/_____ **Social Security** _____-_____-_____

Please Check One for **Preferred Phone Number**

□ **Home Phone** _____-_____-_____

□ **Cell Phone** _____-_____-_____

□ **Work Phone** _____-_____-_____

Email_____

Emergency Contact_____

Phone_____-_____-_____ **Relationship**_____

Marital Status □ Single □ Married □ Domestic Partner □ Divorced □ Widowed

Occupation_____ **Employer**_____

My Injury is the Result Of □ Auto Accident □ Work Injury □ Slip/Fall □ Sports Injury □ Post-Surgery □ Recurring Illness □ Other _____

Describe *How* and *Where* the Injury Occurred _____

_____

DRIVER'S LICENSE AND INSURANCE CARDS ***Please Give All Cards To Front Desk To Copy***

1. ***Primary*** **Insurance Carrier**_____

Name of Insured_____ **DOB**_____/_____/_____ **Relationship**_____

2. ***Secondary*** **Insurance Carrier**_____

Name of Insured_____ **DOB**_____/_____/_____ **Relationship**_____

3. ***Tertiary*** **Insurance Carrier**_____

Name of Insured_____ **DOB**_____/_____/_____ **Relationship**_____

☐ **I Do Not Have Health Insurance**

MOTOR VEHICLE ACCIDENT / LIABILITY INSURANCE (if applicable)

Auto Insurance Carrier_____ **Auto Policy Holder's Name**_____

Claim#_____ **Date of Accident** _____/_____/_____ **Accident State**_____

Claim Adjuster_____ **Phone#** _____-_____-_____

This is *My* Auto Insurance Policy Y / N **This is the *Other Driver's* Insurance Policy** Y / N

WORKER'S COMPENSATION INSURANCE (if applicable)

Work Comp Insurance Carrier_____ **Claim#**_____

Claim Adjuster_____ **Phone#** _____-_____-_____

Date of Accident _____/_____/_____ **Accident State** _____

ATTORNEY INFORMATION FOR THIS INJURY (if applicable)

Attorney Name_____ **Phone#** _____-_____-_____

I hereby certify that all the above information is true to the best of my knowledge X_____

Signature of Patient, Parent, or Legal Guardian