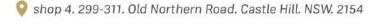


Patient Registration Form

Name:					
First	Middle		ast	Suffix	
Date of Birth: Tricare and TriWest)	Social Security #	#:	(I	Required for WC, MVA,	
Gender: Male Fer	nale				
	Street Apt.	City	State	Zip	
Primary Phone: (Secondary Phone: (Type (H)(W)Type(H)(W)(C) /)(C)			
Email:					
Reminder Call Option	ns: ☐ Primary or ☐ Secondar	ry Phone			
☐ Online Ad ☐ Other:	TAR Staff Event Promoti			Google Search ☐ Mailing Ad	
Emergency Contact: _		Phone:(_)	_Relationship:	
Diagnosis (or body par	t to be treated):		🗆 L	eft \square Right \square Bilateral	
Referring Physician Name:		Is my Primary Care Physician Yes No			
Primary Care Physician (PCP):		Office location:			
	on file with your Health Instour assigned PCP immediat				
	ny Physical Therapy facility of insurance limits No	y in the curi	rent year?		
	ent surgery? ☐ Yes ☐ No S o an accident? ☐ Yes ☐ No			ecident type)	
	rk				







Primary Insurance N	nary Insurance Name:Subscriber ID#:						
Group/Policy #:		Are you the subs	Are you the subscriber? Yes No				
			F	Relationship:			
Address on file:							
	Street	City	State	Zip			
Secondary Insurance Name: Subscriber ID#:							
	oup/Policy #: Are you the subscriber? \[\text{Yes} \text{No} \]						
				Relationship:			
				•			
	Street	City	State	Zip			
Tertiary/HRA/HSA	Information:						
	rance Name:Subscriber ID#:						
Group/Policy #:		Are you the subscriber? Yes No					
				Relationship:			
				P .			
	Street	City	State	Zip			
		•		•			
Have you received any Home Healthcare Services? ☐ Yes -*Please see Medicare Questionnaire ☐ No Have you been discharged from Home Healthcare? ☐ Yes - Date of Discharge: ☐ No							
If you are a Medicare	beneficiary, out	tpatient therapy will need to	be postpone	ed until after all Home			
0 0		erged per Medicare Regulatio		J			
Please present all	l medical ins	urance cards and a ph	ioto ID to	the front desk staff and			
advise if these are	e not the mos	st current copy or if v	ou are ex	pecting to receive newer			
				your medical record for			
nearm insurance	iraua reguia	ations. Thank you for	your coo _l	perauon:			
D :: ./G ::							
Patient/Guardian Sign	ature		Date				

💡 shop 4. 299-311. Old Northern Road. Castle Hill. NSW. 2154