MED STAR
SPECIALIST CLINIC

Patient Registration Form

Name:

_____

First **Middle** **Last** **Suffix**

Date of Birth: _____ **Social Security #:** _____ (*Required for WC, MVA, Tricare and TriWest*)

Gender: □ Male □ Female

Mailing Address:_____ _____
Street Apt. City State Zip

Primary Phone: (____)_____ Type (H)(W)(C)
Secondary Phone: (____)_____Type(H)(W)(C)

Email: _____

Reminder Call Options: □ Primary or □ Secondary Phone

How did you hear about MEDSTAR?
□ My Doctor □ MEDSTAR Staff □ Event Promotion □Family/Friend □Self □ Google Search □ Mailing Ad □ Online Ad □ Other: _____

Emergency Contact:_____ **Phone:**(____) _____**Relationship**: _____

Diagnosis (or body part to be treated): _____ □ Left □ Right □ Bilateral

Referring Physician Name: _____**Is my Primary Care Physician** □ Yes □ No

Primary Care Physician (PCP): _____ **Office location:**_____

Is this the same PCP on file with your Health Insurance Carrier? □ Yes □ No*
***If No**, please update your assigned PCP immediately by calling Member Services on the back of your insurance card.*

Have you treated at any Physical Therapy facility in the current year?
□ Yes- *Visits may affect insurance limits* □ No

Is this related to a recent surgery? □ Yes □ No **Surgical Date:** _____
Is this injury related to an accident? □ Yes □ No (If yes, complete form for accident type)

Accident Type: □ Work □ Auto □ Slip/Fall □ Other _____
Do you have an HRA or HSA Account? □ Yes □ No

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Primary Insurance Name: _____Subscriber ID#: _____
Group/Policy #: _____ **Are you the subscriber?** ☐ Yes ☐ No
Subscriber Name:_____ **Date of Birth:**_____ **Relationship:** _____
Address on file:_____
Street City State Zip

Secondary Insurance Name: _____ Subscriber ID#: _____
Group/Policy #: _____ **Are you the subscriber?** ☐ Yes ☐ No
Subscriber Name:_____ **Date of Birth:**_____ **Relationship:**_____
Address on file:_____
Street City State Zip

Tertiary/HRA/HSA Information:
Insurance Name: _____Subscriber ID#: _____
Group/Policy #: _____ **Are you the subscriber?** ☐ Yes ☐ No
Subscriber Name:_____ **Date of Birth:**_____ **Relationship:** _____
Address on file:_____
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, outpatient therapy will need to be postponed until after all Home Healthcare Services have been discharged per Medicare Regulations.

Please present all medical insurance cards and a photo ID to the front desk staff and advise if these are not the most current copy or if you are expecting to receive newer cards soon. We are required to retain photocopies of these in your medical record for health insurance fraud regulations. Thank you for your cooperation!

_____ _____
Patient/Guardian Signature Date