ORS PHYSICAL THERAPY WWW.ORSPT.COM | CHC CERTIFIED HAND CENTER WWW.ROCKFORDHAND.COM | BRS PHYSICAL THERAPY WWW.BRSPT.COM

PATIENT REGISTRATION FORM

Welcome to our Clinic! Please check the clinic where you will be attending therapy:

☐ **ORS of Dixon** - (815) 284-1700
☐ **ORS of Byron** - (815) 234-5553
☐ **ORS of Rockford** - (815) 227-1700
☐ **CHC - Rockford** - (815) 226-8780
☐ **Belvidere** - (815) 547-4733

About You:

Date of Birth:____/____/_____ Date of Injury (if applicable):____/____/_____

Last Name:_____First Name:_____MI:_____

Patient's Address:_____Apt. #: _____

City:_____ State:_____ Zip: _____

Social Security #_____-_____-_____ Gender (circle one): Male Female

Marital Status (circle one): Married Single Divorced Widowed Other

Where We Can Reach You:

Home Phone: (____)_____-_____ Cell Phone: (____)_____-_____

Work Phone: (____)_____-_____ Fax #: (____)_____-_____

Email Address: _____

Emergency Contact Information:

Last Name:_____First Name:_____MI:_____

Relationship to Patient (circle one): Spouse Parent Child Other _____

Phone: (____)_____-_____

Patient's Employment Information:

Employment Status (circle one): Employed Retired Student Not Employed Self-Employed Active Duty

Company Name: _____

Company Address: _____

City:_____ State:_____ Zip: _____

Referral Information:

Referring Physician's Name: _____

How did you choose our clinic (circle one)?

Doctor Case Manager Insurance Yellow Pages Friend Other_____

Is your injury related to (Check one and answer related questions):

_____Work Injury

If so, are we billing a work comp carrier/insurance? YES/NO
If so, please make sure you complete the Work Comp form.

_____Sports Injury

If so, are we billing a school insurance? YES/NO

If so, please make sure you provide us with the necessary billing information.

_____Auto Accident

If so, are we billing the auto insurance? YES/NO

If so, please make sure you complete the Auto Accident form.

_____Age Related Injury

_____Other (explain): _____

_____ _____

Name of Person Completing Form (print) Date Completed

If the Insured/Card Holder's Name is Different than the Patient Name, Complete this Section:

Relationship to Patient (circle one): Spouse Parent Other _____

Date of Birth:____/____/_____

Last Name:_____First Name:_____MI:_____

Insured's Address (if different than patient):_____Apt. #: _____

City:_____ State:_____ Zip: _____

Social Security #_____-_____-_____ Gender (circle one): Male Female

Marital Status (circle one): Married Single Divorced Widowed Other

Employment Status (circle one): Employed Retired Student Not Employed Self-Employed Active Duty

Employer Name:_____Employer Ph.: _____

Contact Information for Insured (if different than patient):

Home Phone: (____)_____-_____ Cell Phone: (____)_____-_____
Work Phone: (____)_____-_____ Fax #: (____)_____-_____
Email Address: _____