



HULST JEPSEN
PHYSICAL THERAPY

Patient Registration Form

Clinic Location: _____ Patient No.: _____

Patient First Name: _____ M.I.: _____ Last Name: _____

Nickname: _____ Gender: Male Female

Date of Birth: _____ Social Security number _____

Emergency Contact: _____ Phone #: _____

Mailing Address:

PO Box -or- Street Address _____ Apt./Suite/Building # _____

City _____ State _____ Zip _____

		OK to Call	Best Time to Call
Home Phone:	() - _____	<input type="checkbox"/>	_____
Work Phone:	() - _____	<input type="checkbox"/>	_____
Cell Phone:	() - _____	<input type="checkbox"/>	_____

Marital Status: <input type="checkbox"/> Single	Employment Status: <input type="checkbox"/> Full-Time	<input type="checkbox"/> None
<input type="checkbox"/> Married	<input type="checkbox"/> Part-Time	<input type="checkbox"/> Student
<input type="checkbox"/> Separated	<input type="checkbox"/> Self Employed	<input type="checkbox"/> Retired
<input type="checkbox"/> Divorced	<input type="checkbox"/> Active Duty	<input type="checkbox"/> Unknown
<input type="checkbox"/> Widowed	<input type="checkbox"/> Disabled	

Patient Employer: _____ Spouses Employer: _____

Insurance Subscriber's DOB (please fill in if you are not the subscriber): _____

PCP/Family Physician name: _____

Is this injury a result of a work or auto related accident? Yes _____ No _____
(If yes, you **MUST** provide us with that insurance information)

How did you hear about us? (Circle one)

Doctor Previous patient A friend or relative Yellow Pages Website Home Care Agency
Insurance Other _____

PATIENT INSURANCE VERIFICATION:

HJPT FEIN: 30-0002044

Clinic Location: _____ **RT#:** _____ **Name:** _____

Primary Insurance: _____ Subscribers Name: _____
Verify ALL insurances including Medicare!

Subscribers DOB: _____ Relationship to Subscriber: Self Spouse Child

PRIMARY INSURANCE VERIFICATION: Effective Date: _____

Patient Co-Pay: \$ _____ Patient Deductible: _____ Amount Met: \$ _____

% Insurance Covers: _____ OOPMax \$ _____ Amount Met: \$ _____

Co-insurance: _____ Does Physical Therapy need to be Pre-Certified? Yes No

ID/Contract No.: _____ Group No. _____

Visit Limitations: _____ PT visits used this year: _____

Spoke With: _____ Flex account _____ HSA _____

Phone: _____ Fax: _____

Person Authorizing PT: _____ Auth/Ref No.: _____

Visits Allowed: _____ Through Dates: _____

SECONDARY INSURANCE VERIFICATION: Effective Date: _____

Secondary Insurance: _____ Subscribers Name: _____

Subscribers DOB: _____ Relationship to Subscriber: : Self Spouse Child

Patient Co-Pay: \$ _____ Patient Deductible: _____ Amount Met: \$ _____

% Insurance Covers: _____ OOPMax \$ _____ Amount Met: \$ _____

Co-insurance: _____ Does Physical Therapy need to be Pre-Certified? Yes No

ID/Contract No.: _____ Group No. _____

Visit Limitations: _____ PT visits used this year: _____

Spoke With: _____ Flex account _____ HSA _____

Phone: _____ Fax: _____

Person Authorizing PT: _____ Auth/Ref No.: _____

Visits Allowed: _____ Through Dates: _____

Patient

Signature: _____ **Date:** _____