



HULST JEPSEN
PHYSICAL THERAPY

Patient Registration Form
(Front Patient / Backside Staff)

Clinic Location: _____ **Patient No.:** _____

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

Nickname: _____ Gender: Male Female

Date of Birth: _____ Social Security: _____

Driver's License #: _____

Emergency Contact: _____ Phone #: _____

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

City State Zip

Physical Address: _____
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: Single Employment Status: Full-Time None
 Married Part-Time Student
 Separated Self Employed Retired
 Divorced Active Duty Unknown
 Widowed 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)

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: _____

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: _____

Phone: _____ Fax: _____

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

Visits Allowed: _____ Through Dates: _____

Patient

Signature: _____ **Date:** _____