PHYSICAL THERAPY
INSTITUTE OF ILLINOIS

Patient Registration

Today's Date ____/____/_____

Patient Information

Last name _____ First _____ Middle-I. _____

Date of Birth ____/____/_____ Age _____ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Sex: ☐ Male ☐ Female

Home Address:

_____

Address City State Zip Code

Phone: _____ ☐ Home ☐ Cell Phone (Please specify who's cell phone) _____

☐ Work ☐ Other _____

Phone: _____ ☐ Home ☐ Cell Phone (Please specify who's cell phone) _____

☐ Work ☐ Other _____

Phone: _____ ☐ Home ☐ Cell Phone (Please specify who's cell phone) _____

☐ Work ☐ Other _____

E-mail: _____

Who referred you to our office?

☐ Physician _____

Name Address Phone

☐ Website ☐ Newsletter ☐ Yellow Pages ☐ Patient ☐ Family Member ☐ Neighbor ☐ Insurance ☐ Online Search

☐ Other:_____

Over Please

Two Convenient Locations

1550 N. Northwest Highway, Suite 120
Park Ridge, IL 60068
847.298.3079 ● 847.298.4019

1009 IL Route 22, Suite 1
Fox River Grove, IL 60021
847.462.8707 ● 847.462.9208

PHYSICAL THERAPY
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Primary Care Physician: _____
Name Address Phone

Primary Language: _____

Race: ☐ American Indian or Alaska Native ☐ Black or African American ☐ Chinese ☐ Filipino ☐ Japanese ☐ Multiracial
☐ Native Hawaiian or Other Pacific Islander ☐ White or Caucasian ☐ Other _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Occupation: _____

Employer: _____
Name Address Phone

Employment Status: ☐ Retired ☐ Full-time employed ☐ Part-time employed ☐ Unemployed ☐ Student ☐ Child

Responsible Party (If patient is under 18 years of age)

Last name _____ **First** _____ **Middle-I.** _____

Date of Birth ____/____/_____ Age _____

Sex: ☐ Male ☐ Female

Home Address:

_____
Address City State Zip Code

Phone: _____ ☐ Home ☐ Cell Phone (Please specify who's cell phone) _____
☐ Work ☐ Other _____

Phone: _____ ☐ Home ☐ Cell Phone (Please specify who's cell phone) _____
☐ Work ☐ Other _____

E-mail: _____

Patient's relationship to responsible party: ☐ Child ☐ Other _____

PHYSICAL THERAPY
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Insurance

Primary Insurance:

Insurance Company: _____

ID #: _____

Group #/Name: _____

Subscriber Name: _____

Subscriber Date of Birth: _____/_____/_____

Subscriber Address: _____
Address City State Zip Code

Subscriber Phone: _____ ☐ Home ☐ Cell Phone ☐ Work ☐ Other _____

Subscriber Phone: _____ ☐ Home ☐ Cell Phone ☐ Work ☐ Other _____

Sex: ☐ Male ☐ Female **Patient's relationship to insured party:** ☐ Child ☐ Spouse ☐ Other _____

Secondary Insurance:

Insurance Company: _____

ID #: _____

Group #/Name: _____

Subscriber Name: _____

Subscriber Date of Birth: _____/_____/_____

Subscriber Address: _____
Address City State Zip Code

Subscriber Phone: _____ ☐ Home ☐ Cell Phone ☐ Work ☐ Other _____

Subscriber Phone: _____ ☐ Home ☐ Cell Phone ☐ Work ☐ Other _____

Sex: ☐ Male ☐ Female **Patient's relationship to insured party:** ☐ Child ☐ Spouse ☐ Other _____

Work Related Injury

Insurance Carrier Name: _____

Insurance Carrier Address: _____
Address City State Zip Code

Insurance Carrier Phone: _____

Claim Number: _____

Date of Injury: _____

Claim Adjuster Name/Phone/Fax: _____

Nurse Case Manager Name/Phone/Fax: _____

Attorney Name/Phone/Fax: _____

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Emergency Contact

Nearest friend or relative not living with you _____

Phone #: _____ _____ **Relationship to patient** _____

Insurance Authorization and Assignment (Please read and sign)

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to Orthopaedic Surgery Specialists, Ltd./Physical Therapy Institute of Illinois, Ltd., and authorize them to furnish information regarding my illness to my insurance carrier. ***I understand that I am responsible for any amount not paid for by my insurance.***

_____ _____

Patient/Guardian Signature **Date**

Appointment Policies (Please read and sign)

KINDLY GIVE AT LEAST 24 HOURS NOTICE FOR CANCELLATION OR RESCHEDULING. Please be aware, not giving 24 hours notice will result in a $15.00 charge.

PLEASE BE TIMELY FOR APPOINTMENTS. If you arrive more than 15 minutes late for your scheduled appointment, you may have to be rescheduled. This is for the benefit of you and other patients being treated.

WHEN ABLE, PLEASE SCHEDULE YOUR APPOINTMENTS ONE WEEK IN ADVANCE TO ENSURE THE TIMES THAT YOU NEED. Appointment times given one week do not automatically follow through to the subsequent weeks.

The patient and therapist have discussed the importance of frequency and duration.

THANK YOU FOR YOUR COOPERATION.

_____ _____

Patient/Guardian Signature **Date**

_____ _____

Therapist Signature **Date**

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