CORWIN THERAPEUTICS PATIENT REGISTRATION FORM
PLEASE PRINT ALL INFORMATION

Name: _____ S/S #: _____ DOB/Age: _____

Address: _____ Home Phone: _____ Sex M or F Marital Status: S M D W

_____ Cell Phone: _____ Spouse's Name: _____

_____ E mail: _____ Spouse's Phone: _____

Out of State Address: _____ Out of State Phone: _____

If minor or if applicable: Parent/ Legal Guardian: _____ Relationship to pt: _____

Guardian Address: _____ Guardian Phone #: _____

IS THIS A WORK RELATED INJURY? Yes or No Claim # _____ Date of Accident: _____

IS THIS AN AUTO ACCIDENT RELATED INJURY? Yes or No Claim # _____ Date of Accident: _____

IS THIS A LIABILITY INJURY? Yes or No Claim # _____ Date of Accident: _____

ADJUSTOR'S NAME: _____ Adjustor's Phone: _____

ATTORNEY'S NAME: _____ Attorney's Phone: _____

Employment Status: Employed Full Time Employed Part Time Self Employed Retired

Employer's Name: _____ Employer's Address: _____

Employer's Phone Number: _____ _____

Occupation: _____ _____

Name of nearest relative not living with you: _____ Phone: _____

Name of nearest friend not living with you: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Referring Doctor: _____ Primary Doctor: _____

Diagnosis: _____ Onset Date: _____

**********PLEASE HAVE ALL INSURANCE CARDS AND NUMBERS AVAILABLE**********

NAME OF PRIMARY INSURANCE COMPANY: _____ Policy Number: _____

ADDRESS: _____

PHONE NUMBER: _____ Group # : _____

NAME OF SECONDARY INSURANCE COMPANY: _____ Policy Number: _____

ADDRESS: _____

PHONE NUMBER: _____ Group #:: _____

**********INFORMATION PERTAINING TO PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT**********

Name of Insured if other than self: _____ DOB of the insured: _____

Address (if different): _____ Phone: _____

********AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION, ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY**********
I authorize the treatment for Physical, Occupational and/or Speech Therapy Services. I authorize the release of information for claim purposes and understand that payment for these services will be directed to University Rehabilitation. I understand that in the event I do not have supplemental/secondary insurance or if my insurance company denies payment, I will be fully responsible for the balance.

_____ Or _____

Patient Signature Date Legal Guardian Signature Date

How did you hear about our facility? (*Please circle one or if not listed below please let us know how you heard about us in the space provided.*)

White pages Yellow pages Newspaper Magazine ad Friend Family Doctor Radio TV Neighbor Other_____

Did you have any trouble finding us? *YES / NO*

How did you get to your appointment today?

_____