STEAMBOAT
PHYSICAL THERAPY
Percival Creek Professional Plaza | 2102 Carriage Drive SW, Suite B, Olympia, WA 98502
Office 360.866.0408 | Fax 360.866.1165 | Clinic hours: Monday - Friday, 7:00 a.m. to 5:30 p.m.

PATIENT REGISTRATION

Today's Date: ________________

Patient Name: ____ M ☐ F ☐ Date of Birth: _______________

Mailing Address: ____ City: __________________ State: _____ Zip: ___________

Marital Status: S ☐ M ☐ D ☐ W ☐ Phone #: ___________________ Cell #: _______________ SS#: _________________

Referring Physician: ____________________________________ Primary Physician: __________________________________

Employer: __________________________________ Occupation: __________________ Work #: _______________________

Attorney Name (if applicable): ____ Phone #: ______________________________

Spouse or Parent Name: ____ Phone #: ________________________________

Person responsible for bill if not above patient: ____

Person to notify in case of emergency: _________________________________ Phone #: ______________________________

Where did you hear about our clinic? ____

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INSURANCE /IDENTIFICATION

PLEASE PROVIDE YOUR INSURANCE CARD (S) AND PICTURE ID AT YOUR INITIAL VISITS. COPIES WILL BE SCANNED INTO YOUR CHART FOR BILLIING PURPROSES AND IDENTIFICAITON.

<u>Medicare Patients</u>: Have you received home health care in the past 60 days for physical therapy? Y ☐ N ☐

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PRIOR THERAPY TREATMENT THIS CALENDAR YEAR

Number of visits: Massage: __________ Physical Therapy: __________ Speech: __________ Occupational: ___________

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WORKER'S COMPENSATION INSURANCE INFORMATION

Employer: ____________________________________ Contact Person: ____________________ Phone: __________________

W/C Carrier: __________________________________ Claim Manager: ____________________ Phone: __________________

Claim #: _______________________________________ Date of Injury: ____

Number of visits *since start of claim*: Massage: ______ Physical Therapy: ______ Speech: ______ Occupational: _______

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MOTOR VEHICLE ACCIDENT / LIABILITY INSURANCE INFORMATION

Auto Policy Holder's Name: _______________________________ Auto Insurance Carrier: _____________________________

Date of Accident: _____________________________ Claim #: ____

Adjustor: ____ Phone: __________________________