Therapy Center of Cedar Point

Patient Registration Form (Please Print)

Patient Name:_____ Patient SS#:_____
Gender: {_}male {_} female Date of Birth:____/____/_____ Age:_____
Address:_____
City, State, Zip:_____
Home Phone:_____ Cell Phone:_____
Email Address:_____

Patent/Guardian Information (If patient is under 18 years of age):
Parent/Guardian Name:_____ Relationship to Patient:_____

Referring Physician:_____

What is the reason for today's visit? _____

Emergency Contact Information:
Name:_____ Phone #:_____ Relationship:_____

How did you hear about Therapy Center of Cedar Point:
{_}Doctor {_}Family/Friend {_}Yellow Pages {_}Website Other:_____

Insurance Information: (Please provide insurance cards)

Primary Insurance:
Insurance Name:_____
Policy Holder:_____
Policy Holder SS#:_____
Policy Holder Birth Date:___/___/_____
Relationship to Patient:_____

Secondary Insurance:
Insurance Name:_____
Policy Holder:_____
Policy Holder SS#:_____
Policy Holder Birth Date:___/___/_____
Relationship to Patient:_____

Workers Compensation Claim Information:
Claim #:_____ Employer:_____
Claims Adjuster/Case Worker:_____ Phone #:_____

Signature {Patient/Guardian}_____ **Date:**_____