



Patient Registration Form

Please check which clinic you will be attending therapy.
Please remember to bring your picture ID and insurance cards.

- { } Belvidere Physical Therapy- Belvidere, IL { } Marengo Physical Therapy- Marengo, IL
{ } McHenry County Physical Therapy- McHenry, IL { } Ogle County Physical Therapy- Byron, IL
{ } Poplar Grove Physical Therapy- Poplar Grove, IL { } Roscoe Physical Therapy- Roscoe, IL

Patient Information

Patient Name: _____ DOB: __/__/__
(Last and suffix, i.e. Sr., Jr.) (First) (MI)

Social Security Number: _____ - _____ - _____ Gender: _____ Male _____ Female

Address: _____ City: _____

State: _____ Zip: _____ Marital Status: _____ Single _____ Married _____ Other

Home Phone: (_____) _____ Work/ Cell Phone: (_____) _____

Referring Physician: _____ Primary Physician: _____

Patient/ Guardian Signature: _____ Date: _____

Employment Information

Employer Name: _____

Employer Address: _____

Occupation: _____ Status: _____ Full _____ Part Time _____ Retired _____ Unemployed

Guarantor/ Insured Information

(Individual responsible for payment, if different than patient)

Patient Relationship to Guarantor: _____ Self _____ Spouse _____ Child _____ Other

Name: _____ DOB: __/__/__
(Last and suffix, i.e. Sr., Jr.) (First) (MI)

Social Security Number: _____ - _____ - _____ Gender: _____ Male _____ Female

Address: _____ City: _____

State: _____ Zip: _____ Marital Status: _____ Single _____ Married _____ Other

Home Phone: (_____) _____ Work Phone: (_____) _____

Guarantor Employer Name: _____

Employer Address: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: (_____) _____

Name: _____ Relationship: _____ Phone: (_____) _____

Referral Information

(Please check and note how you heard or were referred to this clinic)

- Physician _____ Advertisement _____ Former patient _____
- Event/ presentation _____ Fitness facility _____ Direct mailer _____
- Other _____