

# Personalized Therapy, LLC

## Occupational & Physical Therapy for Children & Adults

### PATIENT REGISTRATION

Name		Date					
	Last	First	MI				
Address							
	Street	City	State	Zip Code			
Phone w/area code			Work Phone				
Birth Date		E-mail Address		Cell Phone			
Sex	<input type="checkbox"/> Female	<input type="checkbox"/> Male	Marital Status	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
Parents Name (If a minor):							
Father :			Mother:				
Referring Physician			Your Primary Care Physician				
Referred For							
<input type="checkbox"/> Occupational Therapy							
<input type="checkbox"/> Physical Therapy							
Name of person who should receive statement (other than patient)							
Statement Address (If different than patient address)							
Who should we contact in an emergency?				Phone number			
Relationship: <input type="checkbox"/> Spouse				<input type="checkbox"/> Parent			
<input type="checkbox"/> Friend				<input type="checkbox"/> Other			
				Cell/Work Number:			

**INSURANCE INFORMATION – PLEASE GIVE YOUR CARDS TO RECEPTIONIST FOR COPYING  
WE DO NOT FILE SECONDARY CLAIMS.**

Primary Insurance		Phone Number	Fax Number
Subscriber's Name		Birth Date	Relationship to Patient:
ID Number		Group Number	
Do you have Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>MEDICARE HAS AUTOMATIC CROSSOVER FOR SECONDARY INSURANCE, PLEASE COMPLETE THE INFORMATION BELOW</b>	
Secondary Insurance		Birth Date	
ID Number	Subscriber Name:	Group Number	

**PATIENT CERTIFICATION AND SIGNATURE**

I certify that all of the information provided herein is true and correct

Patient/Guardian Signature:

Date:

22593 THREE NOTCH ROAD • CALIFORNIA, MD • 20619  
PHONE: 301.862.2505 • FAX: 301.862.2548

# Personalized Therapy, LLC

Occupational & Physical Therapy for Children & Adults

## PATIENT REGISTRATION

### IF YOU HAD AN ACCIDENT PLEASE COMPLETE THIS SECTION

Date of Accident \_\_\_\_\_ How did it happen?  Auto  Work  Other (location)

Involvement in Accident if Auto  Driver  Passenger  Pedestrian  Cyclist

Attorneys Name/Address/Phone \_\_\_\_\_

Insurance Company (Workers Comp or Auto PIP) \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Claim Number \_\_\_\_\_ Adjuster \_\_\_\_\_ Name of Insured \_\_\_\_\_

### IF YOU ARE SENT FROM STATE AGENCY

Arc (Letter is required) \_\_\_\_\_ Rep Name \_\_\_\_\_

DSS (Letter is required) \_\_\_\_\_ Social Worker Name \_\_\_\_\_

SMCPS (Letter and IEP required) \_\_\_\_\_ Special Ed Supervisor Name \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_

School Name \_\_\_\_\_

### PATIENT CERTIFICATION AND SIGNATURE

I certify that all of the information provided herein is true and correct

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

22593 THREE NOTCH ROAD • CALIFORNIA, MD • 20619  
PHONE: 301.862.2505 • FAX: 301.862.2548