



An outpatient rehabilitation practice that performs physical therapy in the comfort of the patient's home.

(610) 310-0915
FAX (484) 363-5954
www.energy-pt.com

PATIENT REGISTRATION FORM

How did you learn about Energy Physical Therapy?

- Physician referral (name)
Friend/family referral (name)
Our website Other healthcare website
General internet search
Other

PATIENT INFORMATION

Name DOB Sex Male Female
Address City State ZIP
Phone (home) (cell) (work)
Email Social Security #
Employed by Occupation
Emergency contact name Phone

INSURANCE / PAYMENT INFORMATION

Medicare Part B: Yes No Medicare Part C: Yes No Self Pay Yes No
Primary insurance Secondary Insurance
Subscriber Name Subscriber Name
DOB SS# DOB SS#
Relationship to Patient Self Spouse Parent Other
Insurance Number Group Number Insurance Number Group Number

RESPONSIBLE PARTY (OTHER THAN PATIENT)

Is any other person financially involved in this claim? Yes No
If yes, responsible party name Relationship to patient Self Spouse Parent Child Other
Address City State ZIP
Phone (home) (cell) (work)
Employer DOB Social Security #

PRIOR TREATMENT

Have you received physical/speech/or occupational therapy here or with another clinic this calendar year? Yes No
If yes, state reason for treatment
Have you received any IN-HOME health, nursing, physical, occupational or speech therapy in the past 30 days? Yes No
If yes, last treatment date: Last in-home provider name /phone
Have you been discharged from this treatment? No Yes (discharge date)

MEDICAL INFORMATION

Treatment for injury? No Yes: Work Sports Auto Other
Date of injury/onset Injury area (on your body)
Referring physician's name Practice Name Phone
Primary physician's name Practice Name Phone
Diagnosis (for physical therapy)