

ORCAS ISLAND PHYSICAL THERAPY, PLLC

PATIENT REGISTRATION

Today's date: _____ Legal Sex: M ___ F ___ Gender, if different: _____ pronouns _____

Last name: _____ First name: _____ Middle Initial: _____

Date of birth: _____ SS#: _____

Billing address (street or PO Box) : _____

City, State, ZIP _____

Home phone: _____ Cell phone: _____ Work phone: _____

Email address: _____

Emergency person: _____ Phone: _____

Relation to patient: _____

Primary care provider: _____

Referring provider: _____

Primary insurance: _____

Secondary insurance: _____

LABOR AND INDUSTRY CLAIMS ONLY

Claim #: _____ Date of injury: _____

Name of claim manager: _____ Phone: 360-902- _____

Name of employer: _____

Address of employer: _____

Employer Phone: _____ Employer Fax: _____

Your insurance plan may have an annual visit limit for outpatient physical therapy. You are responsible for tracking how many appointments you have had at other clinics. Therapies in hospitals or nursing facilities do not count toward outpatient visit limits.

