Synergy Physical Therapy and Wellness

PATIENT REGISTRATION

PATIENT INFORMATION

Patient Name_____ Date of Birth_____ Age_____

Address_____ City_____ State_____

Zip Code_____ Phone # (Home)_____ (Cell)_____ (Work)_____

SSN_____ Email Address_____

What is the best way to contact you? **CELL**_____ HOME **PHONE**_____ EMAIL_____

Employer_____ Employer Address_____

Who is responsible for the patient's medical expenses? _____

Relationship to patient_____ Phone Number _____

INSURANCE INFORMATION

Policyholder: _____ **Policyholder Date of Birth:** _____

Address (if different than the patient's) _____

Insurance Company_____ ID #_____ Group #_____

PERSON TO CONTACT IN CASE OF AN EMERGENCY

Name_____ Relationship to Patient_____ Contact # _____

REFERRING PHYSICIAN

Name_____ Address_____

Phone Number_____ City/State_____ Zip code_____

ACCIDENT INFORMATION

Is this visit due to an accident/injury? Yes___ No___ If yes, Date of injury_____

Was it work related? Yes___ No___ Brief Description of Accident_____

If workman's compensation, has accident been reported to employer? Yes____ No____

Employer Name_____ Address_____

Supervisor's Name_____ Phone #_____

Auto Accident? Yes___ No___ Liability Insurance Company_____

Policy #_____ Phone #_____ Agent's Name_____

1501 East Fulton Terrace Garden City, KS 67846 p. 620.805.6883 f. 620.805.6886