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# Initial Adult Registration

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**Patient Name:**_____ **Date of Birth:** _____ **Age:** _____
Last First Middle

Address:_____

Social Security #: _____ Marital Status: ☐ S ☐ M ☐ D ☐ W **Gender: ☐ M ☐ F**

Phones: Home: ☐ _____ Work:☐ _____ Cell: ☐ _____

Emails: Home: ☐ _____ Work/Other: ☐ _____

**Preferred Contact (check ONE Phone and Email above)**

**Pref. Language: ☐ English ☐ Spanish ☐ Other:** _____ **Smoking: ☐ Never ☐ Past ☐ Current: Packs/d:**_____

| | |
|---|---|
| Emergency Contact Name: | Relationship |
| Home Phone: | Cell Phone: |

| | | |
|---|---|---|
| Primary Insurance: | Name of Insured | Secondary Insurance: |
| | Relationship to Patient | |
| Plan Type (PPO, HMO, etc): | Insured Date of Birth | Plan Type: |
| | Insured Occupation | |
| High Deductible: ☐ N ☐ Y ☐ ? | Employer | Group # |
| Group # | Employer Address | ID # |
| ID # | | Plan Name |
| Plan Name: | Employer Contact name/phone: | |

**Please provide the name, address, phone & fax # of the following providers, if applicable**

| **Referring Person/Practitioner** | **Primary Physician** | **Pharmacy** |
|---|---|---|
| Specialty (if applicable) | How many years under their care?: | |
| Phone: | Phone: | Phone: |
| Fax: | Fax: | Fax: |

| **Neurologist or Orthopedist** | **Cardiologist** | **Hospital**<br>**Physical Therapist or Chiropractor** |
|---|---|---|
| Phone: | Phone: | |
| Fax: | Fax: | |

| | |
|---|---|
| Do you have a Workman's Claim open? ☐ No ☐ Yes | If yes, Claim # |
| Insurance Carrier: | Contact Person: |
| Address: | Contact's Phone |
| Was patient involved in a motor vehicle accident? ☐ No ☐ Yes | If yes, Claim #: |
| Insurance Carrier: | |
| Is an attorney involved in your case? ☐ No ☐ Yes | If yes, Name: |
| Address | Phone |

I understand that the practice of medicine is not an exact science, and that the results cannot be anticipated. I acknowledge that no guarantees have or will be made to me as the result of examination, procedures or treatment.

The undersigned authorizes the release of medical information to healthcare providers, insurance companies, and/or regulatory agencies, which may be necessary for continuity of care and completion of doctor and hospital claims.

I hereby authorize payment directly to Wyndmoor Rehabilitation Associates, PC of the physician insurance benefits otherwise payable to me for care rendered during the care provided. I understand that I am financially responsible for all charges not covered by my insurance. I agree to be assessed an interest fee of 1.5% per month for unpaid balances beginning at 30 days and a collection fee of 36% for payments past 60 days due.

I certify that I understand the contents of this form, or will ask for and receive explanation before signing below.

_____ _____

Patient Signature (or both parents/guardians if a minor) Date Witness Signature and Date