Bon Secours Sports Medicine and Physical Therapy at Patterson Avenue

Outpatient Registration Form

Today's Date:	**Last Name:**		**First Name:**	**Middle Init.**	**Male / Female**
Maiden Name:	**DOB:**	**Marital Status:**	**Race/Ethnicity:**	**Religion:**	
Social Security #:	**Primary Care Physician:**		**Primary Language Spoken:**		
Date of Accident/Incident or Onset of Recent Symptoms			**Type of Incident:** ☐ **Auto** ☐ **Work** ☐ **No Accident** ☐ **Other:** _____		
Home Address	**Apt #**	**City**	**State**	**Zip Code**	
Home Telephone #	**Cell Phone #**	**Email Address** _____ ☐ **Check this box if you DO NOT want to be contacted via email regarding our services.**			
Employer's Name: *(Please check which applies)* ☐ **FT** ☐ **PT** ☐ **Unemployed** ☐ **Retired** ☐ **Student**			**Employer's Telephone #**		

Primary Ins Holder/Sponsor's name and relationship:	**Insurance company:**
Date of Birth:	**Holder/Sponsor's SSN:**
Secondary Ins Holder/Sponsor's name and relationship:	**Insurance company:**
Date of Birth:	**Holder/Sponsor's SSN:**
Third Ins Holder/Sponsor's name and relationship:	**Insurance company:**
Date of Birth:	**Holder/Sponsor's SSN:**

Emergency Contact Name	**Relationship**	**Home Telephone #**	**Cell Phone #**
Emergency Contact Employer's Name			**Work Telephone #**

Would you like information in reference to financial assistance? Yes No

Do you have transportation issues which may prevent you from attending your therapy? Yes No

Advanced Directive Information:
Written Living Will for Medical Choices: Y N if yes, location: _____

Written Medical Power of Attorney: Y N if yes, location: _____