2001 Westown Pkwy., Suite 107, West Des Moines, IA 50265
Telephone: 515-440-3439

803 Cottage Street, Adel, IA 50003
Telephone: 515-993-5599

PATIENT REGISTRATION FORM

PATIENT INFORMATION (please print) IS PATIENT A MINOR? YES NO

FIRST NAME ______________________ MI __________ LAST NAME ________________________________

M / F BIRTHDATE ____/____/_____ MARITAL STATUS: S / M / D / WI SOC. SEC. # ______-______-______

HOME ADDRESS ____
Street/Apt# City State Zip

HOME PHONE ( ) ______-_______ WORK PHONE ( ) ______-_______ x ____ CELL ( ) ______-_______

EMPLOYMENT STATUS: CIRCLE ONE (do not complete if patient is a minor) FT / PT / RETIRED / UMEMPLOYED

PLACE OF EMPLOYMENT ____

****

***IF PATIENT'S SPOUSE IS SUBSCRIBER TO INSURANCE, COMPLETE BELOW:**

SPOUSE'S NAME ________________________________ SPOUSE'S BIRTHDATE ____/____/_____

SPOUSE'S EMPLOYER ____

****

***IF PATIENT IS A MINOR:**

CUSTODIAL PARENT'S NAME _____________________________ CONTACT PHONE: ( ) ______-_______

IS CUSTODIAL PARENT THE INSURANCE SUBSCRIBER? YES NO

*****IF ABOVE ANSWER IS NO, COMPLETE BELOW:**

SUBSCRIBER'S NAME_____________________________ RELATIONSHIP TO PATIENT ________________

SUBSCRIBER'S BIRTHDATE ____/____/_____

SUBSCRIBER'S ADDRESS ____
Street/Apt# City State Zip

*******PLEASE NOTE!! ALL BILLING STATEMENTS WILL BE MAILED TO CUSTODIAL PARENT!!*******

FAMILY DOCTOR ____

REFERRING DOCTOR, IF ANY ____

****

HOW DID YOU HEAR ABOUT CORE PHYSICAL THERAPY? (please check all that apply)

_____ PHYSICIAN REFERRAL _____ FRIEND/FAMILY _____ADVERTISEMENT _____WEBSITE

OTHER: ____

INSURANCE INFORMATION

PRIMARY INS _______________________________ SECONDARY INS _____________________________

ID# _______________________ GROUP # _________ ID# _______________________ GROUP # _________

SUBSCRIBER _______________________________ SUBSCRIBER _______________________________