



ADVANCED ORTHOPAEDIC
Physical Therapy PSC
Expert Therapy with a Personal Touch

Patient Registration Form

Name _____ Date _____
First MI Last

Address _____
Street City State Zip

Phone (with area code) Home _____ Work _____ Cell _____

Social Security Number _____ Birth Date _____

Sex: Male/Female Marital Status: Single Married Divorced Widowed

Employer _____ Occupation _____

Referring Physician _____ Date of Next Visit _____

Parent (if patient is under 18)

or Emergency Contact Name _____

Phone Number _____ Relationship to Patient _____

Have you had any other Physical Therapy, Occupational Therapy, or Chiropractic Visits
this year?

_____ Yes _____ No If yes, how many? _____

INSURANCE INFORMATION: Please present your card to the front desk
Please be advised, our office only files claims with your primary insurance

Primary Insurance Name _____

Insured Name _____ Insured Birth Date _____

Insured Employer _____

Identification Number _____ Group Number _____

If you had an accident, please complete this section

Date of Accident _____ Where? Auto_____ Work_____ Other_____

Insurance Company (workers comp or auto) _____

Phone _____

Insured Name _____

Claim# _____ Adjuster _____

Please advise us how you learned of our services, or whom we need to thank.

____ I was a former patient ____ Family or Friend* ____ Case Mgr/Adjuster

____ Physician Referral ____ Better Business Bureau ____ Web Page

____ Insurance Company ____ Yellow Pages ____ Other*

____ Radio Advertising

*Family/Friend Name or Other _____

Advanced Orthopaedic Physical Therapy, PSC

9400 Williamsburg Plaza
Suite 100
Louisville, KY. 40222

Phone: (502) 412-4486
Fax: (502) 412-4490
Email: Info@MyAOPT.com