



**Advantage Physical Therapy**  
*and Rehabilitation, LLC*

## Patient Registration Form

<b>Name:</b>	<b>(Last)</b> _____	<b>(First)</b> _____	<b>(MI)</b> _____
<b>Street Address:</b>	_____		
<b>City:</b>	_____	<b>State:</b> _____	<b>ZIP Code:</b> _____
<b>Home Phone:</b>	_____	<b>Work Phone:</b>	_____
<b>Cell Phone:</b>	_____		
<b>E-mail:</b>	_____		
<p>If you choose to share your e-mail address we may occasionally contact you regarding upcoming events &amp; relevant news. Your e-mail address WILL NOT be sold or shared with others. Furthermore, all communications will provide the opportunity to opt out of any further communication.</p>			
<b>Soc Sec No:</b>	_____	<b>DOB:</b>	_____
<b>Sex:</b>	_____	<b>Marital Status:</b>	_____
<b>Spouse's Name:</b>	_____	<b>Spouse's Soc Sec No:</b>	_____

<b>Employer: (If you are under 18 please list your parents' employers, here and under Spouse's Employer)</b>			
<b>Company Name:</b>	_____		
<b>Address:</b>	_____		
<b>City:</b>	_____	<b>State:</b> _____	<b>ZIP Code:</b> _____
<b>Spouse's Employer: (If under 18, please list other parent's employer)</b>			
<b>Company Name:</b>	_____		
<b>Address:</b>	_____		
<b>City:</b>	_____	<b>State:</b> _____	<b>ZIP Code:</b> _____

<b>Referring Physician:</b>	_____		
<b>Address:</b>	_____		
<b>City:</b>	_____	<b>State:</b> _____	<b>ZIP Code:</b> _____

(OVER)

<b>Emergency Contact (Name):</b> _____	<b>Relation:</b> _____	
<b>Address:</b> _____		
<b>City:</b> _____	<b>State:</b> _____	<b>ZIP Code:</b> _____
<b>Phone:</b> _____	<b>Alternate Phone:</b> _____	

**Where did you hear about Advantage Physical Therapy & Rehabilitation, LLC?**

<input type="checkbox"/> My Physician	<input type="checkbox"/> Insurance Company Directory
<input type="checkbox"/> Friend or Relative	<input type="checkbox"/> Home Health Nurse/Therapist

Who can we thank? \_\_\_\_\_

**Print Advertising – Which Publication?**

<input type="checkbox"/> <i>The Bull Run Observer</i>
<input type="checkbox"/> <i>The Heritage Horn</i>
<input type="checkbox"/> <i>The Gainesville Times</i>
<input type="checkbox"/> Other Publication _____

**Other:** \_\_\_\_\_

**Please indicate method of payment for treatment (co-payments, deductibles, co-insurance & non-covered items):**

<input type="checkbox"/> Cash	<input type="checkbox"/> Check	<input type="checkbox"/> Credit Card
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**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_