Providing services in:
Physical Therapy
Occupational Therapy
Speech/Language Pathology
Aquatic Therapy
Special Therapy Programs

PATIENT REGISTRATION FORM

PATIENT INFORMATION

PATIENT NAME: _____SEX: (M F) MARITAL STATUS:_____
LAST FIRST MI
DATE OF BIRTH: _____-_____-_____ SS#: _____-_____-_____ PATIENT #: (OFFICE USE)_____
MO DAY YR
ADDRESS: _____CITY: _____ STATE: _____ ZIP: _____

DAY PHONE: (_____)_____ EVE PHONE: (_____)_____CELL PHONE: (_____)_____

REFERRING PHYSICIAN: _____ PRIMARY CARE PHYSICIAN: _____

REFERRING PHYSICIAN PHONE: (_____)_____ PRIMARY CARE PHYSICIAN PHONE: (_____)_____

RESPONSIBLE PARTY

NAME: _____ SEX: (M F) MARITAL STATUS:_____
LAST FIRST MI
DATE OF BIRTH: _____-_____-_____ SS#: _____-_____-_____ RELATION TO PATIENT: _____
MO DAY YR
ADDRESS: _____CITY: _____ STATE: _____ ZIP: _____

DAY PHONE: (_____)_____ EVE PHONE: (_____)_____CELL PHONE: (_____)_____

EMAIL ADDRESS: _____

INSURANCE

PRIMARY INSURANCE: _____POLICY NUMBERS: _____
(ID#) (GROUP/PLAN #)
POLICY HOLDER: _____ EMPLOYER: _____
LAST FIRST MI
DATE OF BIRTH: _____-_____-_____ SS#: _____-_____-_____ RELATION TO PATIENT: _____
MO DAY YR
PHONE: (_____)_____ _____

SECONDARY INSURANCE: _____POLICY NUMBERS: _____
(ID#) (GROUP/PLAN #)
POLICY HOLDER: _____ EMPLOYER: _____
LAST FIRST MI
DATE OF BIRTH: _____-_____-_____ SS#: _____-_____-_____ RELATION TO PATIENT: _____
MO DAY YR
PHONE: (_____)_____ _____

MINNESOTA MA: ____YES____NO ID#_____ COUNTY WAIVER FUNDS_____

WISCONSIN MA: ____YES____NO ID#_____ COUNTY WAIVER FUNDS_____

(OVER)

8320 City Centre Drive, Suite G • Woodbury, MN 55125
Phone: (651) 738-9888 • Fax: (651) 738-9889 • www.familyachievement.com

OTHER CONTACTS

Please list other individuals who are involved in taking care of the patient, such as spouse or caregiver, with whom you authorize Family Achievement Center to discuss the patient's treatment.

NAME: _____
LAST FIRST MI
RELATION TO PATIENT: _____

ADDRESS: _____CITY: _____ STATE: _____ ZIP: _____

DAY PHONE: (_____)_____ EVE PHONE: (_____)_____CELL PHONE: (_____)_____

EMERGENCY CONTACT: ____YES____NO

NAME: _____
LAST FIRST MI
RELATION TO PATIENT: _____

ADDRESS: _____CITY: _____ STATE: _____ ZIP: _____

DAY PHONE: (_____)_____ EVE PHONE: (_____)_____CELL PHONE: (_____)_____

EMERGENCY CONTACT: ____YES____NO

HOW DID YOU HEAR ABOUT US? Phonebook ___ Website ___ Friend ___ Dr ___ Other_____

AUTHORIZATIONS and ACKNOWLEDGEMENTS

I have received the Notice of Privacy Practices from Family Achievement Center, Inc.

SIGNATURE: X _____DATE: _____

I hereby authorize FAMILY ACHIEVEMENT CENTER to furnish information concerning my illness and treatments to INSURANCE CARRIERS, PHYSICIANS, THERAPISTS, AND/OR OTHER PERSONNEL, who are involved in taking care of the patient. I authorize payment of any medical benefits to FAMILY ACHIEVEMENT CENTER. **I certify that the above information is correct and that I AM RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED.** I permit a copy of this authorization to be used in place of the original.

SIGNATURE: X _____DATE: _____

MEDICARE AUTHORIZATION: I request that payment of authorized medical benefits be made on my behalf to FAMILY ACHIEVEMENT CENTER for services furnished me by this clinic/physician/supplier. I authorize any holder of hospital or medical information about me be released to the HEALTH CARE FINANCING ADMINISTRATION and it's agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

SIGNATURE: X _____DATE: _____

THANK YOU!

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