THE SPORTS AND REHAB CLINIC
PO Box 3421 Stowe, VT 05672 253-5694(P) 253-5697(F)

REGISTRATION FORM

Patient Name: _____ Date_____
Last First M.I.

Mailing Address:
_____
City State Zip

Phone: _____

Date of Birth:_____

Emergency Contact_____
Name Relationship Phone

INSURANCE:
NAME:_____

ADDRESS:_____

GROUP #_____ POLICY #_____

SUBSCRIBER_____

EMPLOYER:_____
(workers comp only) Name Address Phone

REFERRING PHYSICIAN:_____

Address:_____
(if not local)

PRIMARY PHYSICIAN:_____

Medicare patients only:
Have you ever had PT services this year?_____
If yes, Time frame and place_____
Are you presently receiving Home Health Services at this time? _____

How did you hear about us? (Check all that apply)
web site___ AD (which one)_____
Friend___ relative_____ other_____