Registration Form

Patient Name: ____
(Last) (First) (Middle Initial)

Nickname: ______________________

Address: ______________________ City: ____________State: _______ Zip: ______________

Home #:__________________Cell #:____________________ Social Security #: __________________

Date of Birth: ____________ Age _____ Male / Female Marital Status: _______

Student: Y / N Occupation: ______________________Current work Status____________________

Emergency Contact Name: __________________Relationship to Patient: ________ Phone #:_______________

Your E-Mail Address ____

Is this injury: Work Related; Yes or No Accident Related; Yes or No Auto Related; Yes or No (if yes, what state__________)

Date of Injury/Onset of Symptoms: ____________________ Date of Surgery: ____________________

Referring Physician: ____________________ Phone #:____________________

Date of Prescription: ____________________ Date of next Physician visit: ____________________

Are you receiving or have you recently received home health services? Yes No

Are you receiving or have you recently received other therapy services? Yes No

Have you had physical therapy, speech therapy, occupational therapy or chiropractic care provided in your home or in a clinic in the past 12 months? Yes or No

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How did you hear about Michigan Orthopaedic Rehabilitation/Michigan Hand Therapy?

Important! Please Read & Sign

By signing below, I agree that all of the above information is correct, and that I authorize Michigan Orthopaedic Rehabilitation/Michigan Hand Therapy to provide me with therapy services and to furnish my Physician, insurance company, worker's comp carrier or attorney information concerning my injury and treatment. I understand that I am financially responsible for payment of all services that are not paid for by my insurance carrier. Should my account be referred for collections, I will be responsible to pay cost of collection, including legal fees. All checks returned for NSF will be subject to a $30 return fee. (06/10)

Patient Signature (Parent/Guardian if necessary) ______________________ **Date:** __________