In Motion Therapy™

Client Registration Form

Patient Acct # _____ Appt Date, Time _____ Location _____

Treating Therapist _____ Body Part _____

Recent Surgery Yes No Date of Surgery _____

Referral Source Name/Address _____

How did you hear about us? (circle) Friend/Family Sign Website Google
Prior Patient Athletic Trainer Doctor's Order Other

First Name Middle Initial Last Name

_____ _____ _____

Home Address City State Zip

_____ _____ _____ _____

Cell Phone _____ Work Phone _____ Email _____

Date of Birth _____ Gender _____

If under 18, who is responsible for account Relationship to Patient
Primary Health Insurance Company

_____ _____

*REQUIRED regardless of coverage by Workers Compensation, Auto Insurance or Personal Liability Insurance

Insurance Company Phone Member ID# Group #

_____ _____ _____ _____

Policy Holder Name Policy Holder DOB Relationship Policy Holder

_____ _____ _____

Secondary Insurance Company Phone Member ID# Group #

_____ _____ _____ _____

Policy Holder Name Policy Holder DOB Relationship Policy Holder

_____ _____ _____

Works Compensation, Auto Insurance, Personal Liability Insurance (if applicable)

How were you injured (circle one) Work Auto Liability Date of Injury _____

Employer at time of injury _____

Adjuster's Name _____ Adjuster's Phone number _____
Insurance Carrier Name and Address

_____ _____ _____

# of Visists ordered by MD File or Claim Number State accident occured

_____ _____ _____