

NEW PATIENT REGISTRATION BW Wyoming County



Returning Client
 Complementary Consultation
 Functional Capacity Evaluation
 Orientation Done by: _____ on _____.
 Benefits Overview by: _____ on _____.

SCHEDULING

Consultation	Date: _____	Time: _____	With Therapist: _____	By/Date: _____
Evaluation	Date: _____	Time: _____	With Therapist	

1A: INITIAL CONTACT INFORMATION (To be completed by BODYWORKS personnel)	
First & Last Name: _____	
Referred By: _____	Chief Complaint: _____
Mailing Address _____	
Home Phone: _____	Work Phone: _____
Cell Phone: _____	Email Address: _____
Social Security #: _____	Date of Birth: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F
1B: INSURANCE INFORMATION	
Primary Carrier: _____	Identification #: _____
Phone Number: _____	Group Number: _____
Guarantor: _____	Date of Birth: _____
Social Security #: _____	2ndary Ins: _____

2: INFORMATION FOR PATIENT TO COMPLETE	
<i>Review details in 1A & 1B. Complete this section and then provide the receptionist with a copy of your driver's license and insurance information.</i>	
Physical Address _____	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated	Student Status: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Non-Student
Emergency Name: _____	<input type="checkbox"/> Work or <input type="checkbox"/> Cell: _____ Home: _____
Injury Related to: <input type="checkbox"/> Accident <input type="checkbox"/> Automobile <input type="checkbox"/> Work <input type="checkbox"/> None	Onset/Injury Date: _____
Claim Manager _____	Phone Number: _____ Ext: _____
Are you receiving Home Health Services now? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had prior therapy this year? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employer: _____	Location: _____
Work Phone: _____	Occupation: _____
2 nd Insurance: _____	Phone Number: _____
Guarantor: _____	Identification #: _____ Group #: _____
If you're under 18 years old, fill out the section below.	
Legal Guardian: _____	Phone Number: _____
Driver's License #: _____	Social Security #: _____

3: INSURANCE VERIFICATION / OFFICE USE ONLY (If the patient comes back for care for a separate episode, reconfirm this information.)			
Insurance Contact: _____	Network <input type="checkbox"/> In Network <input type="checkbox"/> Out	Effective Date: _____	
Called By/Date: _____	Benefit Yr From: _____	To: _____	
Comments: _____	% Coverage: _____	# of Visits: _____	
	Deductible Amt: \$ _____	Met So Far: \$ _____	
	Coverage Limit: _____	Co Pay: \$ _____	
Claim Mgr Called: _____	On: _____	By: _____	Dates Authorized: From: _____ To: _____