



### Patient Registration

Patient Name: \_\_\_\_\_ Gender: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Business Address: \_\_\_\_\_ Business Phone: \_\_\_\_\_  
\_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
  
Referring Physician: \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_  
How did you hear about Atta Rehab, LLC: \_\_\_\_\_

### Insurance Information

#### ***Primary Insurance***

Insurance Company: \_\_\_\_\_ Policy Holder: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Policy Holder Name and Birth Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
\_\_\_\_\_

#### ***Secondary Insurance***

Insurance Company: \_\_\_\_\_ Policy Holder: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Policy Holder Name and Birth Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
\_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_