ADVANCED HEALTH SYSTEMS

940 Buena Vista, Amarillo, Texas 79106
Patient Information and Registration Form
This Information is Confidential

Patient's Full Name: _____ Last Four SS#: _____ Date: _____

Permanent Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Date of Birth: _____ Age: _____ Sex: M F

Cell Phone: (____) _____ Date of Onset / Injury: _____

Are you currently receiving any other medical treatment for the same condition: Y N

If YES circle all that apply: Speech Therapy Occupational Therapy Home Health

Chiropractic Other: _____

Have you received any medical treatment for the same or another condition this year: Y N

If YES circle all that apply: Speech Therapy Occupational Therapy Physical Therapy

Home Health Chiropractic Other: _____

Was This A Job Related Injury? Y N **Claim # _____** If YES, do you have legal representation: Name of Attorney: _____ Phone Number: _____

Was This A Motor Vehicle Accident? Y N **Claim # _____** If YES, do you have legal representation: Name of Attorney: _____ Phone Number: _____

EMPLOYER INFORMATION

Employer: _____ Phone: (____) _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name: _____ Relationship: _____

Home / Cell Phone: _____ Work Phone: _____

If patient is under the age of 18, Parent or Legal Guardian must sign below giving consent for the above named patient to receive Physical Therapy treatments.

Parent / Legal Guardian Signature: _____