ViaFit
Patient Registration Form

PATIENT INFORMATION

Gender ☐Male ☐Female Marital Status ☐Married ☐Single ☐Divorced ☐Widowed

Name: First Middle Initial Last

Date of Birth Social Security Number Current Employer

Address City State Zip Code

( ) ( )

Primary Phone Secondary Phone Email Address

Emergency Contact (Name) Relationship to Patient Phone Number

( )

Referring Physician Phone

( )

Primary Care Physician Phone

INJURY INFORMATION

Is your condition the result of an injury? ☐Yes ☐No ☐Work ☐Auto ☐School ☐Other

Date of Injury _____

If injury is work related:

Employer Name _____

Address _____

City _____ State _____ Zip Code _____

Contact Person _____ Phone:( ) _____

Claim # _____

If injury is a result of an automobile accident:

Name of Adjuster _____

Phone:( ) _____

Claim # _____

INSURANCE INFORMATION

Primary Insurance Policy Number Group Number

Address/Phone

Name of Insured Date of Birth Relationship (SELF/ SPOUSE/CHILD/ OTHER)

Secondary Insurance Policy Number Group Number

Address/Phone

Name of Insured Date of Birth Relationship (SELF/ SPOUSE/CHILD/ OTHER)

I certify that the information provided above is true and accurate to the best of my knowledge.

Patient or Responsible Party Signature Date

Printed Name Relationship to Patient