

Therapy House

(262)619-3265

700 Villa Street - Racine, WI 53403

FAX (262)619-3263

Adult Registration Information

Patient Name:(M / F) _____ SSN#: _____

Address: _____ D.O.B.: _____

_____ Home Phone: _____

Referred By: _____ Work Phone: _____

Reason for Referral: _____

Insurance Company: _____ Phone #: _____

Insured Name: _____ D.O.B.: _____ ID/SS #: _____

Employer: _____ Group #: _____

Benefits: _____

Co-Pays: _____ Deductibles: _____

Claims Address: _____

Managed Care Company: _____ Phone #: _____

Precert Required? Yes / No Authorization #: _____

Number/Dates of visits Auth'ed: _____

Secondary Insurance: _____ Subscriber #: _____

Employer: _____ Group#: _____