BRADFORD REGIONAL MEDICAL CENTER
116 Interstate Parkway, P.O. Box 0218, Bradford, Pennsylvania, 16701-0218
FAX EXPRESS - PHONE (814) 362-4222

SMART REGISTRATION

Date Therapy Began ______________________________ _____ One Time Visit "O"
_____ PT _____ OT _______ SMART _____ HOST Account "R"
Patient Name ____________________________________ Birthdate ___________________
Patient Address ____
City, State, Zip ____________________________________ Social Security #: ______________
Home Phone ____________________________ **Work Phone** _________________________
Employer ___________________________ **Employer Address**: _________________________
Emergency Contact ____________________ Emergency Contact _________________________
Relationship _________ Phone ____________ Relationship___________ Phone ____________

ATTENDING PHYSICIAN: ____
DIAGNOSIS: ____
Primary Care Physician: ____
Date Onset: ________ **(11) Symptoms Or injury? ___ Y ___ N Accident Date:** _______________
Description: ________ (01) Motor vehicle ________ (04) Work Related ________ (05) Other Injury
Liability Insurance: ____________________ **Compensation Carrier:** _______________________
Insurance Address:____
COMP CLAIM #__________________________ **Policy #**______________________________

<u>Primary Insurance</u>: ____
Address ____
Identification # __________________________________ Group # ____________________
Subscriber _____________________________ Subscriber Employer ____________________
<u>Secondary Insurance</u>: ____
Address ____
Identification # __________________________________ Group # ____________________
Subscriber _____________________________ Subscriber Employer ____________________

CONSENT FOR TREATMENT - I hereby give permission to the staff and personnel of Bradford Regional Medical Center to perform such diagnostic studies, to render treatment.

SIGNATURE ____ DATE _______________

Notice of Confidentiality

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Patient Identification Sticker