Orthopedic Physical Therapy

Patient Registration Form

Please Print

PATIENT'S SOCIAL SECURITY # _____ _____ _____

PATIENT'S NAME _____ (FIRST) (MIDDLE INITIAL) (LAST) SEX _____ DATE OF BIRTH _____ AGE _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

HOME PHONE # ( ) _____ (DAY OR EVENING) MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

EMPLOYER _____ OCCUPATION _____ WORK PHONE # ( ) _____ (DAY OR EVENING)

EMPLOYER'S STREET ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

RESPONSIBLE PARTY _____ (FIRST) (MIDDLE INITIAL) (LAST) HOME PHONE # ( ) _____ (DAY OR EVENING) RELATIONSHIP _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

NAME OF SPOUSE / NEXT OF KIN _____ (FIRST) (MIDDLE INITIAL) (LAST) HOME PHONE # ( ) _____ (DAY OR EVENING) RELATIONSHIP _____

SPOUSES / NEXT OF KIN EMPLOYMENT _____ WORK PHONE # ( ) _____ (DAY OR EVENING)

PLEASE LIST ANY DRUG SENSITIVITIES OR ALLERGIES: _____

REFERRING PHYSICIAN _____ PCP / FAMILY PHYSICIAN _____

ACCIDENT INFORMATION

☐ AUTO

DATE OF ACCIDENT / INJURY: ___/___/___ ☐ OTHER:

TIME OF ACCIDENT: ___:___ ☐ AM ☐ PM _____

DATE YOU FIRST SOUGHT TREATMENT: ___/___/___

TIME YOU FIRST SOUGHT TREATMENT: ___:___ ☐ AM ☐ PM

IN WHICH STATE DID ACCIDENT OCCUR?

_____

WORKMAN'S COMPENSATION INFORMATION

IS THIS A WORK-RELATED INJURY OR ILLNESS? ☐ YES ☐ NO

NAME OF WC CONTACT AT WORK: _____ PHONE # _____

DATE OF ACCIDENT / INJURY: ___/___/___

TIME OF ACCIDENT / INJURY: ___:___ ☐ AM ☐ PM

DATE YOU FIRST SOUGHT TREATMENT: ___/___/___

TIME YOU FIRST SOUGHT TREATMENT: ___:___ ☐ AM ☐ PM

INSURANCE INFORMATION

PRIMARY INSURANCE _____ ADDRESS _____ CITY STATE _____ ZIP CODE _____

POLICY # _____ GROUP # _____ SUBSCRIBER NAME _____ RELATIONSHIP _____

SECONDARY INSURANCE _____ ADDRESS _____ CITY STATE _____ ZIP CODE _____

POLICY # _____ GROUP # _____ SUBSCRIBER NAME _____ RELATIONSHIP _____

PAYMENT AND AUTHORIZATION INFORMATION

Your Insurance company will be billed for covered services, and any unpaid balance will be the responsibilty of the patient or responsible party. Parents or guardians are responsible for payment with regards to a minor. The balance of the account will be due and payable if the insuance company has not paid within *45 days or if Worker's Compensation has not paid within 60 days.*

I hereby authorize *Orthopedic Physical Therapy* to release medical information to the insurance company (ies) listed above. Also by my signature and copies thereof, I authorize payment directly to *Orthopedic Physical Therapy* of benefits otherwise payable to me. I understand that I am financially responsible for charges not covered by this authorization. If my account is turned over to an attorney for collection, I will be responsible for all attorney fees which are usually 28% of the unpaid balance.

SIGNATURE _____ DATE