Orthopedic Physical Therapy

Patient Registration Form

Patient's Name: _____ Sex: _____ Date of Birth: _____

Email Address: _____ Patient's Social Security Number: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Preferred Number(s) To Call? ____ Home ____ Work ____ Cell May we Leave a Message? _____ Yes _____No

Responsible Party Name: _____ Date of Birth: _____ Relationship: _____

Email Address: _____ Responsible Party Social Security Number: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Name of policy holder for your insurance: _____ Relationship: _____ DOB of Policy Holder: _____

If you are not available is there anyone else with whom we can speak regarding your visit(s) and/or account(s)? _____ Yes ____ No

If yes, please list the person(s) here: _____

Please List any Drug Sensitivities or Allergies: _____

Referring Physician: _____ PCP/Family Physician: _____

Accident Information and/or Workers Compensation Information:

Date of Accident/Injury: ____/____/____ State of Accident: _____ Date You First Sought Treatment: ____/____/____

Auto: ____ Other: _____ Work Related: _____ Claims Adjuster Name: _____ Claims Adjuster Number:_____

Payment and Authorization Information:

Your insurance company will be billed for covered services, and any unpaid balance will be the responsibility of the patient or responsible party signing this form. Parents and guardians are responsible with regards to a minor. The balance of the account will be due and payable if the insurance company has not paid within 45 days or if Workers Compensation has not paid within 60 days. I hereby authorize Orthopedic Physical Therapy to release medical information to the insurance company (ies). Also by my signature and copies thereof, I authorize payment directly to Orthopedic Physical Therapy of benefits otherwise payable to me. I understand I am financially responsible for charges not covered by this authorization. If my account is turned over to an attorney or agency for collection, I will be responsible for all attorney fess which are usually 33% of the unpaid balance.

Signature: _____ Date: _____