PATIENT REGISTRATION FORM

Last Name: _____ First: _____ Middle: _____

Parent/Legal Guardian Name (if Child is under 18 years old): _____

Address: _____

City/State/Zip Code: _____

Home Phone: _____Cell Phone: _____ Work Phone: _____

Email Address: _____

Social Security#:_____ D.O.B: _____ Sex: _____ Marital Status: _____

Spouse Name: _____ Spouse Phone: _____

Referring Physician: _____ PCP/Family Physician: _____

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List Current Medications, Drug Sensitivities, and/or Allergies: _____

_____

_____

_____

IN CASE OF EMERGENCY (PERSON NOT RESIDING WITH PATIENT):

Name: _____ Relationship To Patient: _____ Phone:_____

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HEALTH INSURANCE

Primary Insurance:_____ Policy#: _____ Responsible Party: _____

Subscriber Name: _____ Subscriber DOB: _____Relationship To Subscriber: _____

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AUTO INFORMATION and/or WORKER's COMPENSATION INFORMATION:

Date of Accident/Injury: _____State of Accident: _____ Date You First Sought Treatment: _____

Auto: _____ Work Related: _____ Other (explain): _____

Claims Adjuster Name:_____ Claims Adjuster Number: _____

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PAYMENT and AUTHORIZATION INFORMATION:

Your insurance company will be billed for covered services, and any unpaid balance will be the responsible party signing this form. Parents and guardian (s) 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 of if Worker's Compensation has not paid within 60 days. I hereby authorize Orthopedic Physical Therapy, Inc to release medical information to the insurance company (ies). Also, by my signature and copies thereof, I authorize payment directly to Orthopedic Physical Therapy, Inc 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 fees which are usually 33% of the unpaid balance.

Patient/Legal Guardian Signature: _____ Date: _____