

PATIENT REGISTRATION FORM

Previous Patient? Y / N

Date: _____

Last Name _____ First Name _____ MI _____

Street Address _____

City _____ State _____ Zip _____ Ailment _____

Telephone: Home (____) ____-____ Cell (____) ____-____

Work (____) ____-____ E-Mail _____

Would you like to receive appointment reminders by E-mail? Y / N

Date of Birth ____/____/____ Social Security # ____-____-____

Emergency Contact _____ Phone (____) ____-____

Referring Physician _____ PCP _____

How Did You Hear About Us? () Ad () sign () doctor () ins. Co. () website () friend _____

Appt time needed: _____ Flexible? Y / N

Insurance: () BC/BS () Medicare () Auto () WC () Other

Do you have secondary insurance? () Yes () No

EMPLOYER INFORMATION

Employer Name _____

Work Telephone (____) ____-____ Job Title _____

Street Address _____

City _____ State _____ Zip _____

RESPONSIBLE PARTY INFORMATION

Who is the Insured?: Self () Spouse () Parent () Other ()

Last Name _____ First Name _____ MI _____

Street Address _____

City _____ State _____ Zip _____

Home Telephone (____) ____-____ Work Telephone (____) ____-____

Date of Birth ____/____/____ Social Security # ____-____-____

I acknowledge that the information stated above is true. I authorize that payment of any insurance benefits for health care services or goods may be made directly to *PHYSICAL THERAPY AND SPORTS PERFORMANCE, LLC*. I also acknowledge by signing below I hereby accept the terms and agreements made by the attached *PHYSICAL THERAPY AND SPORTS PERFORMANCE, LLC* -Patient Registration and Consent for Medical Treatment Form.

Patient/Responsible Party Signature

Relationship

Date