

PATIENT REGISTRATION FORM

Patient's Name _____ Male Female
(First) (Middle Initial) (Last)

Street Address _____ Mailing _____

City _____ State _____ Zip _____

Phone _____ Cell Phone _____ Social Security _____

Date of Birth ____/____/____ Age _____ Email _____

Spouse's Name _____ Date of Birth ____/____/____

Spouse's Employer _____ Phone _____

Address _____

Date of injury, if known _____ Referring Physician _____

Surgery Date: _____ Surgeon _____

Person who recommended our services if other than physician _____

Spouse/Person to Contact in Case of Emergency _____

Contact's Work Phone _____ Contact's Home Phone _____

Have you been a patient here before? _____ Have you had physical therapy or chiropractic in the past 12 months? _____

Employer _____ Phone _____

Address _____

Is this Worker's Comp.? _____ If yes, contact person at work _____ Phone _____

I desire that physical therapy services be provided to me and understand it will be my responsibility to pay for these services if my insurance does not pay or if my insurance benefits are paid to me inadvertently. I request that payment of authorized insurance benefits for services be preassigned to Phoenix Physical Therapy & Sports Performance.

I understand that any balance remaining on my account after 60 days from the date of service is subject to interest charges at the rate of 2% per month. I understand I am responsible for all registered mail fees, court costs, and attorney fees incurred as a result of collection efforts on this account.

Patient signature _____ Date _____

Patient Representative/Legal Guardian, if applicable _____