



PHYSICAL THERAPY GROUP

COMMITTED TO EXCELLENCE

REGISTRATION FORM

(Please Print)

Today's date:		Primary Care Doctor:				
PATIENT INFORMATION						
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.: ()	
P.O. box:	City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone no.: ()	
Chose clinic because/Referred to clinic by (please check one box):						
<input type="checkbox"/> Family		<input type="checkbox"/> Friend		<input type="checkbox"/> Close to home/work		
<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan		<input type="checkbox"/> Hospital		
<input type="checkbox"/> Yellow Pages		<input type="checkbox"/> Other				
Other family members seen here:						

INSURANCE INFORMATION						
(Please give your insurance card to the receptionist.)						
Person responsible for bill:		Birth date: / /	Address (if different):		Home phone no.: ()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Occupation:		Employer:	Employer address:		Employer phone no.: ()	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Please indicate primary insurance		<input type="checkbox"/> Medicare	<input type="checkbox"/> BCBS / BCN	<input type="checkbox"/> Aetna	<input type="checkbox"/> United Healthcare	<input type="checkbox"/> Workmen Comp.
<input type="checkbox"/> Medicaid		<input type="checkbox"/> Meridian	<input type="checkbox"/> Auto Insurance	<input type="checkbox"/> Welfare (Please provide coupon)	<input type="checkbox"/> Other	
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: \$
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other						
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other						

IN CASE OF EMERGENCY				
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: ()	Work phone no.: ()
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.				