PATIENT REGISTRATION

Patient:* *(Please provide your legal name as it appears on your insurance card)

Patient Last Name: ________________________________ First: _____________________ M.I:___________

Address: ____ City: ______________ State: ______ Zip: ______

Home ph: _____________________Cell ph: ____________________Work ph: ______________ Ext: ______

Date of Birth: ___/___/___ Age: ______SS#: ______ -______-______Gender: M F Marital Status: S M W D

Employer: ______________________________________ Address: ____________________________________

Primary Care Physician: _____________________________Referring Physician: _______________________

Have you used physical therapy this year? ___________________________RX Date: __________________

Mailing address: (if different than patient's address) ____

Who should we contact in case of emergency? __________________________Phone:____________________

Spouse or Guardian:

Last Name: _______________________________________First: _____________________MI: ___________

Address: ____ City: ______________ State: ______ Zip: ______

Date of Birth: ___/___/___ Age: _______SS#: ______ -______-______ Cell ph: ________________________

Employer: ________________________________Work Ph: _____________________ Ext: _______________

Insurance:* *(please list insurance name and provide copy of your card)

1st Ins. Company: ________________________ If Medicaid: Passport provider? _______________________

Insured's Name: ____________________________Date of Birth: ___/___/___SS#: ______ -______-_______

ID/Policy #____Group#________________________________

2nd Ins. Company: __________________________ If Medicaid: Passport provider? _____________________

Insured's Name: ____________________________ Date of Birth: ___/___/___SS#: ______ -______-_______

ID/Policy #____Group#________________________________

If you have had an accident, please complete this section:

Date of accident: __________________How did it happen? Auto: ________Work: ________Other: ________

In which State did the accident occur? ____

Insurance Company: (worker's comp or your auto insurance) ______________________________________

Address: _______________________________________Phone:___________________________________

Claim Number: _______________________Adjuster: _____________________

Please tell us how you learned of our service or whom we can thank.

__ I was a Former Patient __Web Page __Former Patient: _______________________

__ Doctor Recommendation __Yellow Page __ Family or Friend: _____________________

__Newspaper __Clinic Sign __Other: ________________________________

Financial Policy

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above named insurance carrier(s). I permit a copy of this authorization to be used in place of the original. This authorization may be revoked in writing either by me or the above named carrier at any time. I certify that I represent only myself or individuals for whom I am guardian and am not here on behalf of a third party. I authorize treatment by any or all providers and professional staff affiliated with **Northwest Physical Therapy, Inc.**

******Patients carrying Medicare or Medicaid may be billed for services******

By signing below I confirm that I have read and understand the financial policy.

X____ X_________________________

Signature of Patient/Legally responsible party Date