NEW PATIENT REGISTRATION RECORD

PATIENT INFORMATION

Patient Name:_____________________________ Occupation:___________________________________

Address:_________________________________ Place of employment:__________________________

City:____________________________________ Is patient a student, minor or have a caretaker?

State:_____Zip:________ Yes _____ No____

Home phone:_____________________________ Parent/Guardian/Caretaker name:

Work phone:_____________________________ ____

Cell phone:______________________________ Address and Phone if different than Patient:

Date of Birth:_______ Age:___ Sex: M__ F__ ____

Patient's SSN:___________________________ School:_______________City:__________________

Emergency contact person and phone #:____

Email:___________________________________ Would you like to receive billing statements via email? Y/N

How did you hear about us? ________________________

INJURY INFORMATION

Date of Injury: _______________ Work related? Yes____No____ Auto accident? Yes____ No____

Other Cause: ____

REFERRAL INFORMATION

Referring Physician's Name:

____

Have you been seen here before? Yes____No____

If yes, when? ______________

INSURANCE INFORMATION

Primary Insurance Information:

Name of Insurance Co.:_________________________

Policy ID#:______________________________________

Group#:____

Patient relationship to subscriber:

Self Spouse Child Other

Subscriber information(if not patient):

Name:______________________________

SSN:_______________________________

DOB:______________________________

Employer:___________________________

Secondary Insurance Information:

Name of Insurance Co:__________________________

Policy ID#:______________________________________

Group#:____

Patient relationship to subscriber:

Self Spouse Child Other

Subscriber's information(if not patient):

Name:______________________________

SSN:_______________________________

DOB:______________________________

Employer:___________________________

I, the undersigned, assign directly to Tice Valley Physical Therapy all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Tice Valley Physical Therapy to release all information necessary to secure payment for benefits.

X____

Signature (Parent/Guardian if Patient is a minor) Relationship to Patient Date