Complete Physical Therapy

Registration Form

Section I: Patient Information

Name:_____ Date:_____
Address:_____City:_____ State:_____Zip:_____
Phone (____)_____ Work Phone (____)_____ Cell Phone (____)_____
Date of Birth: _____ Email: _____
Referring Physician:_____ Phone (____)_____Fax (____)_____
Address: _____ City: _____ State: _____ Zip: _____
Primary Care Physician: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone (____)_____Fax (_____)_____
How did you hear about us?_____

Section II: Responsible Party

Relationship to Patient: ⇗Self ⇗Spouse ⇗Parent ⇗Other
Name: _____ Date of Birth:_____
Address:_____City:_____
State:_____City:_____Zip:_____ Work Phone (____)_____
Cell Phone ( )_____Cell Phone (____)_____

(Please provide insurance card and driver's license to be copied.)

Section III: Insurance Information

Primary Insurance_____ Plan Type_____
Policy Holder's Name_____ Policy Holder's Birth Date_____
Policy Number_____ Group No_____
Secondary Insurance_____ Plan Type_____
Policy Holder's Name_____ Policy Holder's Birth Date_____
Policy Number_____ Group No_____

Section IV: Worker's Compensation or Motor Vehicle Information Only

Is this problem related to a ----- ⇗ Motor Vehicle Accident or **⇗Work Injury**
If you answered Yes to either of the above; please complete the following insurance information.....

PIP or worker's Compensation Carrier _____ Phone(___)_____
Address:_____ City:_____ State:_____Zip:_____
Adjustor's Name:_____ Claim #:_____ Date of Injury:_____
Attorney Name:_____ Phone (____)_____
Address:_____City:_____State:_____Zip:_____

I hereby authorize the release of medical information necessary to report a claim to my plan(s). I understand that I am financially responsible for benefits not covered by insurance plan(s). The information provided above is factual to the best of my knowledge. A copy of this signature is valid as the original.

Signed:_____ Date:_____ (rev.4/13)