PATIENT REGISTRATION FORM

Patient Information

Last Name First MI	Date of Birth	Age	Gender ☐ M ☐ F
Primary Address	Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced		

City	State	Zip	Home Phone	Work Phone

Cell Phone	Email Address	Social Security Number

Occupation	Employer

Secondary Address

City	State	Zip	Secondary Home Phone

Insurance Information ☐ Individual ☐ WC ☐ Auto ☐ Medicare

Person responsible for bill	Relationship	Social security number	DOB	Address, if different

Home Phone Number	Occupation	Employer	Employer Phone Number

Primary Insurance	ID Number	Group Number

Policy Holder Name
Billing Address

Relationship of Insured to Patient	Insurance Company Phone Number	Co-Payment	Self-Pay ☐ Yes, patient Informed of Fees

Secondary Insurance	ID Number	Group Number

Policy Holder Name
Billing Address

Relationship of Insured to Patient	Self-Pay ☐ Yes, patient Informed of Fees

OVER

If you have had an accident (work or auto) please fill out this section:

Date of Accident	How it happened ☐ Work ☐ Auto ☐ Other	Insurance Company ☐ Worker's Comp ☐ Auto Insurance	
Address	Phone number	Claim number	
Adjuster	Name of insured	Attorney's name	Attorney's phone number

Emergency Information

Contact	Relationship	Phone

I hereby assign, transfer, and set over to Partners in Motion Physical Therapy all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of my medical information needed to determine these benefits. The authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient's Signature____***Date***:____________________________