PERfect FORMation PT

PATIENT REGISTRATION FORM

Patient Information:

Patient Name: _____

Address: Street: _____City: _____

State: _____ Zip Code: _____ Birth date: ____/_____/_____

Home Phone: (_____)_____ Cell Phone: (_____)_____-_____ Work Phone: (_____)_____-_____

Email: _____

Preferred Contact Method: – (Circle) – Home Phone / Cell Phone / Work Phone / Email / Text Cell
Can we leave a detailed voice message?: – (Circle) – Yes / No

Social Security Number: _____-_____-_____

Worker's Comp Case Number: _____ MVA Claim Number: _____

Referred By: _____

Person to Notify in Emergency: _____

Relationship: _____Phone #: (_____)_____-_____

Insurance Information:

Primary Insurance: _____
Address: _____
_____
Phone #: _____

ID #: _____
Group #: _____

Full Name of Insured: _____
Date of Birth of Insured: _____/_____/_____
Relationship to Patient: _____

Secondary Insurance: _____
Address: _____
_____
Phone #: _____

ID #: _____
Group #: _____

Full Name of Insured: _____
Date of Birth of Insured: _____/_____/_____
Relationship to Patient: _____

Permission to Disclose Information for Payment

I hereby provide permission to PERfect FORMation Physical Therapy Inc to disclose any information necessary to my insurance company for reasons of payment. I understand and agree that any fees not covered by my insurance company will be my responsibility for payment to PERfect FORMation Physical Therapy Inc. I declare that the information provided to PERfect FORMation Physical Therapy is to the best of my knowledge correct and true.

If any changes are made to your insurance coverage during treatment, it is the responsibility of the patient to notify the provider at once.

Signature: _____ Date: _____

If patient is a minor, authorization to treat patient.

Signature of Guardian: _____ Date: _____