PATIENT REGISTRATION

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

Patient Last Name: _____ First: _____ M.I:_____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home ph: _____Cell ph: _____Text Appt Reminders Y / N Cell Carrier:_____

Date of Birth: ____/____/____ Age: _____SS#: _____ -_____-_____ Gender: M / F Marital Status: S M W D

Employer: _____ P.T. / F.T. / Self- Employed (circle one) Work Ph:_____

Primary Care Physician: _____Referring Physician: _____

Has patient used physical therapy this year? Y / N - If so, where and how many visits?_____

Who should we contact in case of emergency? _____Phone:_____
Relationship of Emergency contact (circle one) Spouse Relative Friend Other _____
Do we have your permission to leave account and/or personal information with your spouse and/or emergency contact? Y / N

Spouse or Guardian:

Last Name: _____First: _____MI: _____
Date of Birth: ____/____/_____ Age: _____SS#: _____ -_____-_____ Cell ph: _____

Insurance: (Please complete ONLY if name on Insurance card is NOT patient)

1st Ins. Company: _____ Patient Relationship to person listed on Card: **_____**
Insured's Name: _____Date of Birth: _____/_____/_____SS#: _____ -_____-_____
ID/Policy #_____Group#_____
2nd Ins. Company: _____ ID/Policy # **_____**

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.**_____**

By signing below, I am authorizing Northwest Physical Therapy to contact me at the above phone and mobile/cell numbers to leave voicemail messages about appointment times if I am unable to accept the call.

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

X_____X_____
S***ignature of Patient/Legally responsible party*** ***Date***