NEW PATIENT REGISTRATION RECORD

PATIENT INFORMATION

Patient Name:_____

Address:_____

City:_____

State:_____Zip:_____

Home phone:_____

Work phone:_____

Cell phone:_____

Date of Birth:_____Age:____Sex: M___F___

Patient's SSN:_____

Occupation:_____

Place of employment:_____

Is patient a student, minor or have a caretaker?

Yes _____ No____

Parent/Guardian/Caretaker name:

_____

Address and Phone if different than Patient:

_____

School:_____City:_____

Emergency contact person and phone #:_____

Email:_____

How did you hear about us? _____

- Would you like to receive billing statements via email? Y/N
- Do you give us permission to speak to spouse or other designated person for billing purposes? Y/N

  If yes, list name and phone #:_____

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