

WEST END
R e h a b
Physical Therapy

REGISTRATION FORM

(Please Print)

Today's date:		Primary Physician:			
PATIENT INFORMATION					
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):		Birth date: / /	Age:
Street address:		Social Security no.:		Home phone no.: ()	
P.O. box:	City:	State:		ZIP Code:	
Occupation:	Employer:		Employer phone no.: ()		
Chose clinic because/Referred to clinic by (please check one box): <input type="checkbox"/> Dr. <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital					
<input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Close to home/work <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other					
Other family members seen here:					

INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:	Birth date: / /	Address (if different):		Home phone no.: ()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Occupation:	Employer:	Employer address:		Employer phone no.: ()	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Please indicate primary insurance <input type="checkbox"/> Aetna <input type="checkbox"/> Cigna <input type="checkbox"/> Blue Cross/Blue Shield <input type="checkbox"/> Unicare					
<input type="checkbox"/> Automobile <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Workers Compensation <input type="checkbox"/> Other					
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: \$
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: ()
			Work phone no.: ()
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.			
_____		_____	
<i>Patient/Guardian signature</i>		<i>Date</i>	