PATIENT REGISTRATION FORM

Patient Information:

Last Name First Initial			Date of Birth	Age
Address			Marital Status	Gender
City	State	Zip	Home Phone	
Work Phone	Cell Phone		Email Address	
Driver's License Number		Social Security Number		

Responsible Party Information:

Person Responsible for Bill	Relationship
Social Security Number	Date of Birth

Insurance Information: [ ] Individual [ ] WC [ ] Auto [ ] Medicare

Primary Insurance	ID Number	Group Number
Policy Holder Name		
Billing Address		
Secondary Insurance	ID Number	Group Number
Policy Holder Name		
Billing Address		
Relationship of Insured to Patient	Self-Pay [ ] Yes, Patient Informed of Fees	

Referring Information:

Diagnosis	Date of Injury	Area of Injury
Referring Physician	Phone Number	Fax Number
Family Physician	Phone Number	Fax Number

Emergency Information:

Contact	Relationship	Phone

I hereby assign, transfer, and set over to ProFormPT all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of 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:***____________________________