Complete Body Physical Therapy

Patient Registration Form

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Last Name: First: Middle:	Marital Status: M D W S	Date of birth: / /
Social Security number:	Home number: ( )	Cell number: ( )
Mailing address:	City:	State:	ZIP Code:
Occupation:	Employer:	Employer phone no.: ( )

Referred to clinic by: ❑ Dr. ❑ Insurance Plan ❑ VNA ❑ Family ❑ Friend ❑ Close to home/work ❑ Bargain Buyer ❑ Other:
Name of person:

INSURANCE INFORMATION

Name of Primary Insurance:			ID #:
Subscriber Name:	Date of birth:	Address (if different):	Employer:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑Other:

Name of Secondary Insurance:			ID#
Subscriber Name:	Date of birth:	Address (if different):	Employer:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑Other:

Related to: ❑ Auto ❑ Work ❑ Personal Injury ❑ N/A Date of Injury: / /

EMERGENCY CONTACT INFORAMTION

Emergency Contact Name:	Relationship:
Phone 1: H/W/C	Phone 2: H/W/C

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Complete Body Physical Therapy. I understand that I am financially responsible for any balance as determined upon claims processing. I also authorize Complete Body Physical Therapy or insurance company to release any information required to process my claims.

Patient signature: ____Date:_________________

Guardian signature: ____Date:__________________