
McDonough
PHYSICAL THERAPY

# REGISTRATION

Legal Name:_____ Sex: _____D.O.B:_____
Address: _____ City: _____
State: _____ Zip Code: _____ Home Phone: _____
Email Address: _____ Cell Phone: _____

Occupation:_____ Employer:_____
Work Phone #:_____

Primary Ins Policy:_____ ID #: _____
Claims Phone #: _____ Relationship to Insured: _____
Insured's Legal Name: _____Group#: _____ D.O.B.: _____

Secondary Ins Policy:_____ ID #: _____
Claims Phone #: _____ Relationship to Insured: _____
Insured's Legal Name: _____ Group#: _____ D.O.B.: _____

** If responsible party is different than above, please fill out the following information.

Responsible Party: _____ Relation: _____ SS#:_____
D.O.B: _____ Home Address: _____
Employer: _____ Work Phone #:_____

Emergency Contact: _____ Relation:_____
Phone #: _____

**PROFESSIONAL SERVICES MUST BE PAID AT THE TIME THEY ARE RENDERED.**

Assignment of benefits: I hereby authorize payment directly to McDonough Physical Therapy of benefits due me for services described above. I understand I am financially responsible for charges not covered by this authorization.

Release of information: I hereby authorize McDonough Physical Therapy to release any information required to process this claim form.

_____ _____
Patient Signature Date