



McDonough PHYSICAL THERAPY

REGISTRATION

Legal Name: _____ Sex: _____ D.O.B.: _____
 Address: _____ City: _____
 State: _____ Zip Code: _____ Home Phone: _____
 S M W D (Please Circle) SS#: _____ - _____ - _____ TDL#: _____
 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