



Patient Registration

Name: (Last) (First) (MI)			Social Security #: - -	
Address:			Date of Birth:	Gender: M <input type="checkbox"/> F <input type="checkbox"/>
City:	State:	Zip:	Marital Status: Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/>	
Home Phone: ()			Work Phone: ()	
Cell Phone: ()			E Mail:	
Emergency Contact:		Phone: ()	Relationship:	
I authorize PCPT to leave messages regarding my appointments/therapy at this number: HM <input type="checkbox"/> WK <input type="checkbox"/> CELL <input type="checkbox"/> E Mail <input type="checkbox"/> Initial: _____				

Insurance Information

Case in Litigation: Yes <input type="checkbox"/> No <input type="checkbox"/>	Name of Legal Counsel:	Phone #: ()
Primary Insurance Name:		Policy ID#:
Phone #: ()		Name of Policy Holder:
Secondary Insurance Name:		Policy ID#
Phone #: ()		Name of Policy Holder:

Parent or Legal Guardian Information

Name: (Last) (First) (MI)	Social Security #: - -
Address:	Home Phone: ()

Physician Information

Referring Physician:	Phone #: ()
Primary Physician:	Phone #: ()

Physical Therapy Information

Have you had Physical Therapy treatment in the past year? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If yes, where?	How long?	
How did you choose <i>Personal Care Physical Therapy</i> for your current therapy? Physician Referred: <input type="checkbox"/> Advertisement/ Phone Book: <input type="checkbox"/> Family/Friend: <input type="checkbox"/>		

Authorizations

<ul style="list-style-type: none"> I understand I am financially responsible to <i>Personal Care Physical Therapy</i> for charges not covered by my insurance carrier. I authorize direct payment of benefits otherwise payable to me to this facility. I understand that I am responsible for forwarding any checks to this facility. I also understand that I will be responsible for 100% of the total amount due if I neglect to forward the checks in a timely manner. In the event there is a potential blood or body fluid exposure to a patient or employee I consent to the administration of an HIV and HBV Antibody test. I agree to pay all interest, court costs, collection and attorney's fees in the event this account is turned over for collections. 	
Signature Patient /Parent or Legal Guardian _____	Date _____