



# REGISTRATION FORM

(Please Print)

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Primary Care Physician \_\_\_\_\_

## PATIENT INFORMATION

Patient's Last Name		First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss	Marital Status (Circle One)	
				<input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former Name)	Birth Date	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Street Address		City	State	ZIP Code	Social Security	Home Phone No. ( )
P.O. Box		City		State		ZIP Code
Occupation		Employer			Employer Phone No. ( )	
Who can we thank for referring you to us? (Please check one box)				<input type="checkbox"/> Dr. _____	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family		<input type="checkbox"/> Friend		<input type="checkbox"/> Close to Home/Work		<input type="checkbox"/> Yellow Pages
				<input type="checkbox"/> Other _____		
Other Family Members Seen Here _____						

## INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date	Address (if different)		Home Phone No.	
	/ /			( )	
Is this person a patient here?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Occupation	Employer	Employer Address		Employer Phone No. ( )	
Is the patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Please indicate primary insurance					
<input type="checkbox"/> Medicare		<input type="checkbox"/> Aetna US Healthcare		<input type="checkbox"/> Humana Choice Care	
<input type="checkbox"/> First Health		<input type="checkbox"/> Choice Care		<input type="checkbox"/> Focus Health	
		<input type="checkbox"/> Workers Comp		<input type="checkbox"/> Other _____	
Subscriber's Name		Subscriber's S.S. #	Birth Date	Group #	Policy #
			/ /		
Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____					
Name of Secondary Insurance (if applicable)			Subscriber's Name	Group #	Policy #
Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____					

## IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No.	Work Phone No.
		( )	( )

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

X \_\_\_\_\_  
 PATIENT/GUARDIAN SIGNATURE DATE