

PHYSICAL THERAPY SPECIALISTS CLINIC, INC.
NEW PATIENT REGISTRATION

Patient Name _____ Birth Date _____ Age _____
Address _____
City _____ State _____ Zip code _____
Phone Day () _____ Evening () _____ Cell Phone () _____
Patient's Sex Male Female Marital Status: Married / Widow / Divorced / Separated / Single
Social Security # _____ Email Address _____
Employment Status Full-Time / Part-Time / Not-Employed
Student Status Full-Time / Part-time / N/A Are you a high school athlete? Yes / No

Patient's Employer _____ Occupation _____
Address _____
City _____ State _____ Zip Code _____
Phone # () _____ Ext# _____ E-mail Address _____

Parent/Spouse/Guardian _____
Address _____
Phone # () _____ Employer _____
Employer Phone () _____ DOB: _____ SS# _____

Emergency Contact: _____ Phone # _____

Primary Insurance: _____ Primary Insured Person: _____
Claim Address: _____ Insured Address: _____
Group #: _____ Insured Phone # _____
Member I.D. # _____ Social Security # _____
Effective Date: _____ DOB: _____ Sex: Male Female

Secondary Insurance/W/C/MVA: _____ Primary Insured Person: _____
Claim Address: _____ Insured Address: _____
Group #: _____ Insured Phone # _____
Member I.D. # _____ Social Security # _____
Effective Date: _____ DOB: _____ Sex: Male Female

What is the amount of your annual insurance deductible _____ Co-Insurance _____
Do you have a Copay? Amount _____ How will you be paying for services – Cash, Check or Credit Card
Name and address of Bank for checking account _____
Account # _____
Name of Credit Card _____ Account # _____

Was your injury a result of: Employment related / Auto Accident / Other

Most insurance companies do not cover 100% of your treatment cost. Because of this and the extreme delay in receiving payment from insurance companies, you will be asked to pay your estimated part of the charges at the times of service. Insurance will be billed weekly for you, if we do not receive payment from them within a reasonable amount of time the account is your responsibility.

I hereby authorize payment directly to Physical Therapy Specialists Clinic, Inc. of the Insurance Benefits otherwise payable to me.

Signature _____ Date _____

IF YOU CANNOT KEEP YOUR SCHEDULED APPOINTMENT, AND IF YOU DO NOT GIVE 24 HOURS NOTICE, YOU WILL BE CHARGED A \$25.00 MISSED VISIT FEE.