



Patient Registration Form

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip code: \_\_\_\_\_ SS number: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Please check all the ways we can contact you

Home phone: \_\_\_\_\_  Cell phone: \_\_\_\_\_  SMS/Text on cell

E-mail address: \_\_\_\_\_  Work phone: \_\_\_\_\_

Please keep in mind that communications via email over the internet is not a secure form of communication.

Marital Status:  Single  Married  Divorced  Widowed

Employer and Employer phone number: \_\_\_\_\_

Who is your General Physician: \_\_\_\_\_

2nd contact person name/address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Relation: \_\_\_\_\_

Please Fill Out The Following Information If Different From Above

Primary
Policy holder information: \_\_\_\_\_
(name, address, Insurance plan name)

Policy holder DOB: \_\_\_\_\_ ID/SS#: \_\_\_\_\_ Group number: \_\_\_\_\_

Secondary
Policy holder information: \_\_\_\_\_
(name, address, Insurance plan name)

Policy holder DOB: \_\_\_\_\_ ID/SS#: \_\_\_\_\_ Group number: \_\_\_\_\_

Is this work related? Yes No If yes, Date of Injury: \_\_\_\_\_

Employer address: \_\_\_\_\_

Is this Motor Vehicle Accident related? Yes No If yes, State \_\_\_\_\_ and Date of accident: \_\_\_\_\_

How did you hear about us?
 Physician Referral, who referred \_\_\_\_\_  Family or Friend
 Industry  Advertisement (please list) \_\_\_\_\_  Other (please list) \_\_\_\_\_

I hereby authorize and consent to treatments/services for myself, or on the behalf of the above named patient, performed by the staff at Orthopedic & Sports Physical Therapy and/or as directed by my referring physician, that are deemed necessary in the course of care. I assign medical benefits payable for these services directly to Orthopedic & Sports Physical Therapy. I authorize the release of any medical or other information necessary to process claims for these services.

I understand that I am responsible for payment of any applicable co-payments, co-insurance, deductibles or non-covered services at the time of service. In the event that I default on payment of my account, I agree to be responsible for collection fees and interest due on amounts in default.

I understand that my health information will be used for treatment, payment and healthcare operations in accordance with the Notice of Privacy Practice.

By providing your contact information, you agree to receive information, such as appointment reminders, patient surveys and other information relating to your therapy services via the communication channels you provided above.

\_\_\_\_\_  
Patient/Legal Guardian Signature Date

Relationship to Patient: \_\_\_\_\_

\_\_\_\_\_  
Initial I acknowledge receipt of the Notice of Privacy Practices which provides information on how my Protected Health Information may be used or disclosed, if I have any questions I can contact the Compliance Department.