Woodhaven Physical Therapy

PATIENT REGISTRATION INFORMATION

Date:__________________ **SS#**__________________________ **D.O.B**________________________

Name:____

Last First Initial

Address:____**APT**__________________________

City___________________________________ **State**______________________ **Zip**________________________

House Phone__________________________________ **Cell Phone**____________________________

Sex: [] M []F [] Minor []Single [] Married []Divorced [] Widowed []Separated

E-Mail Address:____

Employer____ **Phone**_______________________________

Business Address:____**City**:__________ **State** ____________**Zip**____________

Who referred you to your office?____ ________________

In case of Emergency, who should we contact?___________________________________ **Phone** _________________________

PRIMARY INSURNCE

Person Responsible for Account____

Last First Initial

Relationship to Patient____**D.O.B**________________ **SS#**_____________________

Address ____**City**__________ **State** _____________**Zip**______________

Responsible Party Employed by____

Business Address____

Insurance Company____

Insurance Address____

Subscriber I.D #____**Group**______________________________________

ADDITIONAL INSURNCE (IF APPLICABLE)

Insurance Name ____

Relationship to patient:________________________________ **D.O.B**____________________ **SS#** ________________________

Address ____**APT** _____________

City ____________________________ **State** _________________________ **Zip**________________________

Insurance Company: ____

Insurance Address: ____

Subscriber I.D #____**Group**__________________________________

ASSIGNMANET AND RELEASE

I hereby authorize payment directly to Dr. __________________ all insurance benefit otherwise payable to me for services rendered. I understated that I am financially responsible for all charges whether or not paid by insurance, for all service rendered on my behalf or my dependents.

I authorize the above noted doctor and/ or any provider or services in the office to release any information required to secure the payment of benefit. I authorize the use of this signature on all insurance submissions.

Signature of responsible party:____ Date:____________________

10-06