COMSTOCK PHYSICAL THERAPY PATIENT REGISTRATION

PATIENT INFORMATION

Patient Name_____Birthdate_____Age____ ☐M ☐F

Address _____

City/State/Zip _____

Email Address _____

May we email you flyers, etc.? ☐ Yes ☐ No

Social Security# _____ (Required if we are billing your insurance)

Employer _____Position_____

Referred to this office by _____

VISIT REASON

Problem for which you are seeking treatment: _____

If caused by an accident or injury, how did it happen: _____

_____

_____

Where _____ Date of injury _____

Is it ☐Work-related ☐Auto accident ☐School sports ☐Other

Claim#_____ Attorney Name _____

If this is a workers compensation claim or an automobile claim, please provide your private medical insurance name and ID in the section below.

INSURANCE INFORMATION

Insurance Name _____Insurance Phone#_____

Subscriber Name _____Subscriber Birth date _____

Subscriber ID# _____ Subscriber ID Group#_____

Do you have a secondary insurance plan that covers you? ☐Yes ☐No <u>If yes:</u>

Insurance Name _____Insurance Phone#_____

Subscriber Name _____Subscriber Birth date_____

Subscriber ID# _____Subscriber ID Group#_____

IN CASE OF EMERGENCY:

Name _____Relationship _____

Home Phone# _____Work or Message Phone# _____

I hereby authorize the physical therapists and professional staff to consult, examine, perform, and treat the patient's problem. I understand that I am financially responsible for all charges incurred by me or my dependent.

_____

PATIENT SIGNATURE (Parent or guardian if patient is a minor) *DATE*