RESPONSIVE PHYSICAL THERAPY, INC.

Registration Form

____ ______/______/______
Patient Name (Last, First) Date of Birth

____
Address City State Zip

______/______/______ ______/______/______ _______ ____________________
Telephone Social Security # Sex Marital Status

E-Mail____

Referring Physician:___________________________________Next Dr. Visit__________

_______________________________________ ______/______/______
Employer Name Telephone #

____
Employer Address City State Zip

Whom may we "thank" for referring you?______________________________________

Person to contact in case of emergency:__________________________Phone #__________
Relationship

Have you had Physical Therapy this year? Yes_______ No______

Are Health Care Professionals coming to your home (i.e. nurse, therapist)? Yes______ No______

INSURANCE INFORMATION: Please give insurance cards to staff so that we may make a copy.

Primary Insurance Company:____

Insurance Company Address:____

ID Number:____________________Group #________________Claim #_______________________

Secondary Insurance Company:____

PATIENT RESPONSIBILITY: I Guarantee payment of all charges for services rendered including any costs and/or fees incurred for collection if my account is delinquent. I hereby grant permission for the release of medical records information to my insurance company and doctors. I authorize payment directly to Responsive Physical Therapy, Inc. of insurance benefits otherwise payable to me. I hereby give my Consent for Treatment.

___________________________________ ________________________
Signature Date