Sport & Spine
Physical Therapy and Wellness Center

REGISTRATION FORM

(Please Print)

Today's Date:	PCP:

PATIENT INFORMATION

Patient's Last Name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Social Security No.:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street Address:	Home Phone no.: ( )	Cell Phone no.: ( )

City:	State:	ZIP Code:	E-Mail:

Occupation:	Employer:	Employer Phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ Blue Cross/ Blue Shield	❑ United Health Care	❑ Humana	❑ Cigna	❑ Aetna

❑ AvMed	❑ TriCare (Military)	❑ Medicare	❑ Welfare *(Please provide coupon)*	❑ Other

Subscriber's Name:	Subscriber's S.S. no.:	Birth Date: / /	Group No.:	Policy No.:	Co-Payment: $

Patient's Relationship to Subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of Secondary Insurance (if applicable):	Subscriber's Name:	Group No.:	Policy No.:

Patient's Relationship to Subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to Patient:	Home/Cell Phone: ( )	Work Phone: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*