

Patient Registration

(PLEASE PRINT CLEARLY!)

Patient's Name: _____ SS #: _____
 First Name MI Last Name

Date of Birth: _____ Male Female Single Married Widowed Divorced Separated

Street Address : _____

City/State/Zip Code: _____ Home Phone w/Area Code: _____

Cell Phone w/Area Code: _____ Fax w/Area Code: _____

Spouse's Name: _____ SS #: _____

Spouse's Employer: _____ Spouse's Work Phone #: _____

Patient's Employer: _____ Work Phone w/Area Code: _____

Responsible Party: _____ Relationship: Self Spouse Parent Other: _____

If patient is a Minor, are parents Married Divorced Custodial Parent: _____

Custodial Parent's Home Phone w/Area Code: _____ Work Phone w/Area Code: _____

Custodial Parent's SS #: _____ Date of Birth: _____

In case of emergency, contact (not living with you): _____

Phone Number w/Area Code: _____ Relationship to Patient: _____

Is this work-related? Yes No If yes, date of injury? _____ Claim #: _____

How did this injury happen? _____

Referring Physician's Name & Phone Number: _____

PLEASE PRESENT INSURANCE CARD(S) & PHOTO ID FOR COPYING AND COMPLETE THE REQUESTED INFORMATION

Insurance Company # 1: _____ Phone Number: _____

>>Primary Insured's Name: _____ >>Date of Birth: _____

Policy #: _____ Group #: _____ Relationship: _____

Insurance Company # 2: _____ Phone Number: _____

>>Primary Insured's Name: _____ >>Date of Birth: _____

Policy #: _____ Group #: _____ Relationship: _____

I hereby authorize the payment of medical benefits to Peak Physical Therapy and Sports Medicine Center for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier.

- **I further agree to pay all collections costs, attorney fees, and other collections costs that may be incurred to enforce the collection of any amounts outstanding.**
- **I hereby authorize to Peak Physical Therapy and Sports Medicine Center to release any medical information necessary to complete and process my insurance claims.**

>>Patient's OR Insured's Signature (If patient is a Minor, must have Responsible Party Signature) _____ Date _____

I agree to give Peak Physical Therapy and Sports Medicine Center consent for care and treatment considered necessary and proper in evaluating and treating my condition. I authorize Peak Physical Therapy and Sports Medicine Center to treat me and use my personal health information for healthcare operations. I have reviewed the posted HIPPA privacy policy and a copy of the policy has been offered to me.

>>Patient's Signature (OR Parent if patient is a Minor) _____ Date _____