REGISTRATION FORM
(ALL QUESTIONS MUST BE COMPLETED!)

PATIENT NAME _____E-MAIL _____

ADDRESS_____CITY/ST/ZIP_____ SEX: M/ F

HOME PHONE # _____ CELL # _____

BIRTH DATE _____-_____-_____ AGE____ SOCIAL SECURITY #_____

DRIVERS LICENSE #_____ EXP._____ PATIENTS EMPLOYER_____

EMPLOYER ADDRESS_____CITY_____

MARITAL STATUS_____ SPOUSE'S NAME_____

PARENTS NAME IF PATIENT IS MINOR_____

SPOUSE'S/PARENT'S EMPLOYER_____ PHONE #_____

EMERGENCY CONTACT_____PHONE #_____

REFERRING M.D. NAME _____ OFFICE LOCATION _____

HAVE YOU HAD PHYSICAL THERAPY AT ANOTHER FACILITY THIS YEAR? YES / NO

WHO DO WE BILL? ___ PRIVATE HEALTH INSURANCE ___ MY AUTO INSURANCE

___ WORKER'S COMPENSATION ___ CASH PAY ___ MEDICARE

IF AUTO OR WORK RELATED; DATE OF INJURY _____-_____-_____

IF INJURY, HOW DID INJURY OCCUR? _____

PRIMARY INSURANCE CARRIER NAME _____

ADDRESS_____

INSURED'S NAME _____ RELATIONSHIP _____

INSURED'S CLAIM # / I.D.# _____GROUP #_____

TELEPHONE NUMBER _____ CLAIM EXAMINER _____

SECONDARY OR OTHER INSURANCE _____

BENEFITS AND MEDICAL RELEASE AUTHORIZATION:

- I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THE CLAIM.
- I AUTHORIZE THAT PAYMENT OF MEDICAL BENEFITS SHALL BE PAID DIRECTLY TO **BODYMAX PHYSICAL THERAPY**. I UNDERSTAND I AM RESPONSIBLE FOR ANY AMOUNT **NOT** COVERED BY INSURANCE CARRIER.
- I HAVE READ ALL THE INFORMATION AND I CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.
- I WILL NOTIFY YOU OF ANY CHANGES IN MY HEALTH STATUS, INSURANCE, OR INFORMATION ON THE REGISTRATION FORM.

_____ _____

SIGNATURE DATE

_____ _____

PARENT SIGNATURE (IF PATIENT IS A MINOR) DATE