

Edmonds Physical Therapy & Sports Rehabilitation, P.S.

PATIENT REGISTRATION

FOR OFFICE USE
Acct #:
ICD-9:

PATIENT INFORMATION

Name (Last, First, MI):		Date:
Address:		Phone:
City, State, Zip:		Alt. Phone:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Other		E-mail:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate:	Soc Sec #:
Referred to this office by:		Primary Care Physician:
Patient's Employer:		Spouse's Name:
Address:		Spouse's Employer:
City, State, Zip:		Spouse's Work Phone:
Occupation:		Spouse's Occupation:

INSURANCE INFORMATION

Primary Insurance:		Secondary Insurance:	
Insurance Address:		Subscriber's Name:	
Insurance Phone:		Subscriber's Date of Birth:	
Group#:	ID#:	Group#:	ID#:
Subscriber's Name:		Subscriber's Name:	
Subscriber's Date of Birth:		Subscriber's Date of Birth:	
Subscriber's Employer:		Subscriber's Employer:	
Subscriber's Soc Sec #:		Subscriber's Soc Sec #:	
Subscriber's Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian		Subscriber's Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian	

INJURY INFORMATION

Injured at: <input type="checkbox"/> Home? <input type="checkbox"/> School? <input type="checkbox"/> Work? <input type="checkbox"/> Auto Accident? <input type="checkbox"/> Other:			
Injury date:	Claim #:	Injury date:	Claim #:
Work Related Injury		Auto Accident	
Insurance:		Insurance:	
Adjustor:		Adjustor:	
Adjustor's Phone:		Adjustor's Phone:	
Adjustor's Fax:		Policy Holder:	

EMERGENCY INFORMATION

In Case of Emergency, Please Contact:	
Name:	Relation:
Phone:	Work Phone:

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the health care provider. I am financially responsible for any balance due. I also authorize the health care provider or insurance company to release any information required for this claim.

Signed: X _____