PATIENT REGISTRATION

Name: ____ Today's Date: _______________
Preferred Name:_____________________________________
Address: ____ DOB: _____________ Age:______
City: _____________________________ State: _____________ Zip Code: _______________
Home #: __________________ Work #: __________________ Cell #: ___________________
Email: ____
Employer: _____________________________ Occupation: ____________________________
Emergency Contact: ____________________ Phone #: ______________________________

Reason for today's visit:

____

Referring Dr: ____________________________ Phone #: ______________________________
Primary Care Dr: _________________________ Phone #: ______________________________

INSURANCE INFORMATION:
Insurance Carrier: ____
Subscriber: ________________ DOB: _____________
ID #: ____ Group #: __________________________

CAR ACCIDENT: Date of Accident: __________________
PIP Insurance Co: ___________________________ Claim #: ___________________________
Billing Address: _____________________________ City: _________________ State: _______
Adjuster: ___________________________________ Phone #: __________________________

WORK RELATED INJURY: Department of L&I: or Worker's Comp/Self Insured:
Date of Injury: __________ Claim #: ______________ Employer: _______________________
Adjuster: ______________________________ Phone #: _________________________________
If self insured, please provide billing address:

____
Have you had Physical Therapy in the past related to this claim: YES or NO

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**************WE BILL PRIMARY INSURANCE ONLY**************

I, the undersigned certify that I (or my dependent) have insurance coverage with the above listed insurance and hereby authorize you to evaluate & treat me (or my dependent) & I assign directly to ProFormance Rehab, Inc. all medical benefits, if any, for services rendered. I authorize the release of all information necessary to secure payment of benefits. I authorize the release of medical and billing information to my referring physician or insurance company if requested.

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SIGNATURE OF INSURED/GUARDIAN **DATE**