ProFormance Rehab

PATIENT REGISTRATION

Name: _____ Today's Date: _____
Preferred Name: _____ DOB: _____
Age: _____ Sex: _____ Gender Identity: _____ Pronouns: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone #: _____ Receive Appointment Notification Texts? YES / NO
Email: _____
Employer: _____ Occupation: _____
Emergency Contact: _____ Emergency #: _____

Reason for today's visit:

_____

Referring Dr: _____ Phone #: _____
Primary Care Dr: _____ Phone #: _____

INSURANCE INFORMATION:
Private Insurance: _____
Subscriber: _____ Subscriber DOB: _____
Insurance 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 / NO

I, the undersigned, certify that the above information is correct & 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 & billing information to my referring physician or insurance company if requested.

SIGNATURE OF INSURED/LEGAL GUARDIAN **DATE**