

Peak Form Physical Therapy Patient Registration

Patient Information	This section refers to PATIENT ONLY.	Today's Date:
Name:		Soc Sec #:
Address:		Date of Birth:
City/St/Zip:		Gender:
Home Phone: ()		Female
Cell Phone: ()		Male
Work Phone: ()		Marital Status:
How did you hear about us?:		Married
		Single
		Email:
		Employer:
Purpose of Visit		
Injury:		Diagnosis:
Referring Dr:		Injury Date:
Address:		Script Date:
City/St/Zip:		Dr Phone: ()
Responsible Party	Person who should receive bill.	
Name:		
Address:		
City/St/Zip:		
Relationship:	Self Spouse Parent Other	
Home Phone:	()	
Work Phone:	()	
Primary Insurance	If patient is different than insured, please fill out top section of "Insurance Benefits & Eligibility" form!	
Insured Name:		
Company:		
Claim Phone: ()		
Claims Addr:		
City/St/Zip:		
Are you covered by another plan?	Yes No	
Policy #:		
Group #:		
Member Id #:		
If Auto Accident		
Insurance Co:		
Accident Date:		
Claim #:		
Adjuster:		
If Worker's Compensation		
Employer:		
W/C Carrier:		
W/C Phone: ()		
Accident Date:		
Claim #:		
Adjuster:		
Notify in Emergency		
Name:		Hm Phone: ()
		Wk Phone: ()

I authorize payment of medical benefits from my insurance to Peak Form LLC and the release of any medical information relating to all claims for benefits submitted on behalf of myself and/or dependents. I understand that I am responsible for all charges, including those not covered by insurance. Any money paid to you by your insurance company for services rendered and billed by Peak Form LLC shall be paid to Peak Form LLC immediately upon receipt. **I understand that failure to do so is illegal.**

Signature of Patient/Insured: _____

PatiendRegistration.xls Updated 01/07/2004