INTAKE REGISTRATION FORM

All information is needed for insurance billing, please complete.

PATIENT INFORMATION

Last Name _____First Name _____MI_____

Social Security Number _____DOB _____Gender

Street Address _____City _____

State _____Zip Code _____

Contact Phone# _____Alternate Phone #_____

Marital Status _____ Occupation _____

Email: _____

***How did you hear about us? _____

EMPLOYER INFORMATION

Company Name _____

Address _____

City _____ **State** _____ **Zip Code** _____

EMERGENCY CONTACT INFORMATION

Last Name _____ **First Name** _____

Relationship to Patient _____ **Phone Number** _____

INSURANCE INFORMATION

Name of PRIMARY Insurance Carrier	**Name of SECONDARY Insurance Carrier**
Name of Insured	**Name of Insured**
Name of Policyholder	**Name of Policyholder** **DOB:**
Member ID#	**Member ID#**
Group/Plan#	**Group/Plan#**

I authorize payment of medical benefits to Physical Therapy **Pro Center** for services performed.

I understand that I am responsible for payment regardless of insurance coverage.

Signature _____ Date _____