Registration Form

DATE____________ REFERRING DOCTOR________________________HOME PHONE #___________________

NAME____________________________________SOCIAL SECURITY #___________________________________

MAILING ADDRESS____________________________________CITY______________STATE______ZIP_______

BIRTHDATE_______________AGE_____ STATUS S M W D SEX M F

SPOUSE NAME_____________________________SPOUSE S. S. #__________________BIRTHDATE__________

MAJOR COMPLAINT/DIAGNOSIS____

DATE OF ACCIDENT _________________WORKMEN'S COMP__________AUTO_________OTHER_________

IN CASE OF EMERGENCY CONTACT_____________________________________PHONE#_________________

EMPLOYER NAME
AND ADDRESS____

EMPLOYER PHONE # ______________________________________

Next Doctors Appointment _____________________________________

PRIMARY INSURANCE_______________________________________POLICY ID#_________________________

POLICY HOLDER______________________________________POLICY HOLDER S. S. #___________________

SECONDARY INSURANCE____________________________________POLICY ID #________________________

POLICY HOLDER______________________________________POLICY HOLDER S. S. #___________________

WHO IS RESPONSIBLE FOR THIS BILL____

WILL YOU BE PAYING BY CASH_____________CHECK_____________CREDIT CARD___________________

I acknowledge that the above information is true and correct. I hereby authorize treatment and understand the possible benefits and risks of my treatment. I irrevocably assign all benefits directly to Performance Physical Therapy. I authorize release of any medical records to my doctor, insurance company, attorney, claims adjuster, and my employer. I also authorize any physician or medical facility to release information relevant to Performance Physical Therapy. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services.

SIGNATURE____DATE_____________________________