MCH Physical Therapy Clinic

PATIENT REGISTRATION

Name: *(Last)* _____ *(First)* _____ *(MI)* _____ (Jr., Sr., etc.) Sex: ☐ M ☐ F

Street Address: _____ Apt./ Unit#: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ SSN: _____ Marital Status: _____

Place of Employment: _____

CONTACT INFORMATION *(Check the box next to the best contact number)*

Home Phone: _____ Work Phone: _____

Mobile Phone: _____ Other Phone: _____

Email Address: _____

EMERGENCY CONTACT *(Check the box next to the best contact number)*

Emergency Contact Name: _____ Relation: _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____ Other Phone: _____

PARENT/RESPONSIBLE PARTY FOR PAYMENT

Name: _____ Date of Birth: _____

Address: *(If different from above)* _____

City: _____ State: _____ Zip Code: _____

Phone: _____

INSURANCE INFORMATION

Primary Ins.: _____ Insured Name: _____ DOB: _____

Secondary Ins: _____ Insured Name: _____ DOB: _____

On The Job Injury? ☐ Yes ☐ No Workers' Comp Insurance Co: _____

Date of Injury: _____ Claim#: _____ Adjuster's Name: _____ Auto Accident? ☐ Yes ☐ No

Date of Injury: _____ Claim#: _____ Adjuster's Name: _____

Attorney's Name: _____ Attorney's Phone: _____

PREVIOUS THERAPY INFORMATION

Have you received any other Therapy Services this calendar year? ☐ Yes ☐ No

Have you received, or are you currently receiving, Home Health Therapy? ☐ Yes ☐ No

If yes, please provide dates: _____ and the name of the Home Health Agency: _____

Have you received, or are you currently receiving Chiropractic Treatment? ☐ Yes ☐ No

I hereby authorize payment of medical benefits lo MCH Physical Therapy Clinic, for services furnished to me. I also hereby consent to have treatment and care as prescribed by my physician and/or recommended by the therapist. I also authorize tho therapist to release any infomation in the course of my examination or treatment. This assignment will remain in effect unless revoked by me in writing. A photocopy is to be considered as valid as the original. I HERESY ACCEPT FINANCIAL RESPONSIBILITY FOR ALL CHARGES INCURRED WHETHER OR NOT I HAVE INSURANCE COVERAGE. VERIFICATION OF BENEFITS WE RECEIVE FROM YOUR INSURANCE IS NOT A GUARANTEE OF PAYMENT.

_____ _____

Patient or Responsible Party Signature Date