

New Patient Registration

Personal Information

Last Name: _____

First Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Fax: _____

E-mail: _____

Social Security Number: _____ Marital Status: Married Single

Sex: Male Female Date of Birth: _____

Referring Physician: _____

In case of emergency contact: _____

Phone: _____

Insurance Information

Name of Insured: _____

SS# of Insured: _____

Insurance Carrier: _____ Phone: _____

Policy #: _____ Group #: _____

Employment Information

Employer: _____

Employer Address: _____

Responsible Party: Self / Other If Other, name: _____

Address: _____ Phone: _____

I authorize payment of medical benefits directly to Physiofitness P.T.P.C. for all services rendered. I agree to be responsible for all deductible and co-payment fees. Signature: _____ Date: _____

Please Note: A scheduled appointment must be cancelled at least 24 hours in advance or a \$50 late cancel charge will be assessed. Similarly, if you do not show up for a scheduled appointment, a \$50 fee will be assessed. This fee is not billable to insurance. I have read and understand this policy:

Signature: _____ Date: _____