Advanced Physical Therapy & Ergonomics, Inc.

Patient Registration Form

Name: (First)________________________ (M.I.)______ (Last)________________________

Street Address: ____ Apt. #____________

City: ___________________ State: ______ Zip: _____________ SSN: ___________________

Date of Birth: _________________________ Age: _________________ Sex: _____________

Home Phone: ________________________ Cell Phone: ______________________________

Okay to leave message? ___ Yes ___ No Okay to leave message? ___ Yes ___ No

E-mail Address: ____

How would you like appointment reminders: ___ Call ___ Text ___ Email ______ Other

Person to Contact In Case of Emergency: ____

Phone Number: ___________________________ Relationship: ______________________

Primary Care Dr. __________________________ Phone: ____________________________

How did you hear about us: _____ MD _____ Internet _____ Family/Friend _____ Other

Payment Source: Private Insurance Workers Compensation Self-Pay Auto

Insurance Carrier: _________________________ ID/Claim #: _______________________

Secondary Insurance: ____

ASSIGNMENT OF BENEFITS

I understand that I am responsible for all charges weather or not they are paid by my insurance. I authorize Advanced Physical Therapy & Ergonomics, Inc. to release any information necessary to secure payment of benefits. I authorize my insurance benefits to be paid directly to Advanced Physical Therapy & Ergonomics, Inc. I understand that payment for service is expected at time service is rendered unless my insurance is to be billed.

Advanced Physical Therapy & Ergonomics, Inc. will gladly help obtain insurance coverage information and referrals for you. However, I understand that it is my responsibility to know the coverage and benefits of my insurance plan.

______________________________ ______________________________ ________________

Print Name Signature Date