

GO PHYSICAL THERAPY REGISTRATION FORM

(Please Print)

Today's date:				Primary Care Physician:			
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?			(Former name):	Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.: ()		
P.O. box:		City:		State:		ZIP Code:	
E-mail:				Cell phone no:			
Occupation:		Employer:			Employer phone no.: ()		
Chose clinic because/Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages		<input type="checkbox"/> Other		
Other family members seen here:							
INSURANCE INFORMATION							
(Please give your insurance card to the receptionist.)							
Person responsible for bill:		Birth date: / /	Address (if different):			Home phone no.: ()	
Please indicate primary insurance		<input type="checkbox"/> BCBS- PPO	<input type="checkbox"/> UHC	<input type="checkbox"/> Medicare	<input type="checkbox"/> BCBS- HMO	<input type="checkbox"/> Aetna	<input type="checkbox"/> Humana <input type="checkbox"/> Other
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:		Policy no.:	Co-payment: \$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):			Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Is this a result of a Work Accident?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is this a result of an auto accident?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Claim Number:		Insurance Company Name:		Adjustor/Representative Name:		Phone Number: ()	
Was the accident caused by another person?		<input type="checkbox"/> Yes	<input type="checkbox"/> No				
Do you have any Attorney?		<input type="checkbox"/> Yes	<input type="checkbox"/> No				
Attorney's Name:		Phone Number: ()		Address:			
IN CASE OF EMERGENCY							
Name of local friend or relative (not living at same address):			Relationship to patient:		Home phone no.: ()	Work phone no.: ()	
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the therapist. I understand that I am financially responsible for any balance. I also authorize Go Physical Therapy or insurance company to release any information required to process my claims.							
_____ <i>Patient/Guardian signature</i>				_____ <i>Date</i>			