GO PHYSICAL THERAPY REGISTRATION FORM

(Please Print)

Today's date:	Primary Care Physician:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.: XXX-XX-______	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

E-mail:	Cell phone no:

Occupation:	Employer:	Employer phone no.: ( )

Would you like an appointment reminder?	❑ Text ❑ E-mail ❑ Call ❑ None (**SELECT ONE**)	

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family ___________	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Would you like your statement e-mailed to you? ❑ Yes ❑ No

INSURANCE INFORMATION

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Please indicate primary insurance	❑ BCBS- PPO	❑ UHC	❑ Medicare	❑ BCBS- HMO	❑ Aetna	❑ Humana	❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Is this a result of a Work Accident?	❑ Yes	❑ No	Is this a result of an auto accident?	❑ Yes	❑ No

Claim Number:	Insurance Company Name:	Adjustor/Representative Name:	Phone Number:
			( )

Was the accident caused by another person?	❑ Yes	❑ No

Do you have any Attorney?	❑ Yes	❑ 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.

Patient/Guardian signature *Date*