

# TIMBERLINE PHYSICAL THERAPY REGISTRATION FORM

(Please Print)

Today's date:				Email:			
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.		
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?			Birth date: / /		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address / P.O. Box			Social Security no.:		Home phone : (    )		
Cell Phone:		City:		State:		ZIP Code:	
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"/> Internet			
<input type="checkbox"/> Motor Vehicle Accident		<input type="checkbox"/> Workmen's Comp		<input type="checkbox"/> No Insurance			

INSURANCE INFORMATION			
(Please give your insurance card to the receptionist.)			
Insurance Company:		Address:	Insurance Phone: (    )
Policy Number:	Group Number:		
Employer:	Employer phone no.: (    )		
Are you covered by more than one insurance company? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please indicate primary insurance	<input type="checkbox"/> MVA	<input type="checkbox"/> Work Comp	<input type="checkbox"/> Medicare
			<input type="checkbox"/> Cash
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

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 physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.			
_____ Patient/Guardian signature			_____ Date