

VICTORY PHYSICAL THERAPY PATIENT REGISTRATION

Today's Date _____

Evaluation date _____

Chart # _____

PATIENT INFORMATION:

LAST NAME _____ FIRST NAME _____ MI ___ Sex ___

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PHONE # _____ CELL # _____

DATE OF BIRTH _____ AGE _____ MARITAL STATUS: Married / Single

EMPLOYER _____ FT / PT TELEPHONE _____

EMERGENCY NAME/RELATION _____ PHONE # _____

LEGAL GUARDIAN (IF MINOR) _____

PHYSICIAN INFORMATION:

REFERRING: _____ PRIMARY: _____

DIAGNOSIS: _____ SURGERY: _____

DATE OF INJURY: _____ WORK _____ AUTO _____

BILLING RESPONSIBILITIES:

INSURANCE COMPANY _____ PHONE # _____

ID/CLAIM # _____ GROUP # _____

SUBSCRIBER'S NAME _____

ADJUSTER'S NAME _____ PHONE # _____

SECONDARY INSURANCE: _____ PHONE # _____

ID/CLAIM # _____ GROUP # _____

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1. I authorize my insurance benefits to be paid directly to Victory Physical Therapy.
 2. I am financially accountable for the portion of my balance deemed patient responsibility by my insurance carrier/plan.
 3. I authorize the facility to release any medical records/billing to my referring physician and insurance company.
 4. I am interested in receiving newsletters from Victory Physical Therapy.
Email Address: _____

SIGNATURE: _____ DATE: _____