PROACTIVE HAND AND PHYSICAL THERAPY, LLC
PATIENT REGISTRATION

Name_____ Male / Female _____

Last First Middle Gender Birth Date

_____ S M W D _____

Social Security # Marital Status Occupation

_____

Street Address City State Zip

_____

(CIRCLE PREFERENCE) Home Phone Work Phone Cell Phone

_____ _____

E-mail Address Supervising Physician

Whom may we thank for referring you to our office?_____

STATUS OF CONDITION

Reason for being seen today_____

_____.

Date of Surgery / Injury_____ Have you been seen here before for this condition? Y N

BILLING INFORMATION

_____

Responsible Person's Name DOB Relation to Patient Home/Cell Phone Work Phone

_____

Street Address City State Zip

INSURANCE

_____

Primary Company Address

_____

Phone ID# Group# Subscriber's Name

_____

Secondary Company Address

_____

Phone ID# Group# Subscriber's Name

Accident related to: Work Auto or Other_____
Circle one

_____

Workman's Comp / Auto Ins Carrier Claims Address

_____

Phone Claim# / Policy# Adjuster

Attorney_____ Phone#_____

I hereby authorize PHPT to release any information regarding services rendered by them and allow a photocopy of my signature to be used to file insurance. I hereby authorize and direct payment checks for benefits due me for the services rendered by ProActive Hand and Physical Therapy LLC to be made directly to them regardless of my insurance benefits, if any. I understand I am financially responsible for the fees of services rendered.

_____ _____

Signature Date