Pearson Physiotherapy Specialists, LLC – Patient Registration Form

**********Patient Information**********

Name: (Last)_____**(First)**_____**(MI)**_____

Physical Address:_____**(Apt/Unit#)**_____

City_____**State**_____**Zip**_____

Mailing Address: _____

City_____**State**_____**Zip**_____

Home Phone: (_____)_____**May we leave message?**_____

Cell Phone: (_____)_____**May we leave message?**_____

Social Security #_____**DL#**_____**State of Issue:**_____

Date of Birth: ____/____/_____ Age:_____ Sex: *M / F* Marital Status: *Married Single Divorced*

Student?_____ **E-mail:**_____

Employer Information (Company Name) _____

Address:_____

City:_____**State**_____**Zip** _____

Work Phone (____)_____ **Work Fax (____)**_____

**********Spouse Information**********

Name: (Last)_____**(First)** _____**(MI)**_____

Physical Address:_____ **(Apt/Unit#)**_____

City_____**State**_____**Zip** _____

Home Phone (_____)_____ **Cell Phone (_____)**_____

Social Security#_____-_____-_____**Date of Birth: _____/_____/_____**

Employer Information (Company Name) _____

Address: _____

City:_____**State**_____ **Zip**_____

Work Phone (_____)_____ **Work Fax (_____)**_____

********** **Emergency Contact** **********

Name:_____ **Phone# (_____)**_____

********** **Primary Insurance Information** **********

Physical Therapy is for treatment of (circle one): ***work injury / motor vehicle accident / other***

Date of Injury / Accident / Onset of Problem: ____/____/_____ **Date of Surgery:**____/____/_____

Insurance Company:_____ **Claim#** _____

Policy Holder Name:_____ **Date of Birth:**_____/_____/_____

Policy ID# _____ **SS# of Policy Holder:** _____-_____-_____

********** **Secondary Insurance Information** **********

Insurance Company:_____ **Claim#** _____

Policy Holder Name:_____ **Date of Birth:**_____/_____/_____

Policy ID# _____ **SS# of Policy Holder:** _____-_____-_____

********** **Responsible Party** **********

Name: (Last)_____ **(First)** _____ **(MI)**_____

Physical Address:_____ **(Apt/Unit#)**_____

City_____ **State**_____ **Zip** _____

Mailing Address: _____

City_____ **State**_____ **Zip**_____

Home Phone (____)_____ **Cell Phone (____)**_____

Social Security#_____-_____-_____ **Date of Birth:** _____/_____/_____

How did you hear about us? **Physician / Friend / Insurance / Phone Book / Returning Patient**

How do you plan to pay for deductibles / co-pays / non-covered items? **Cash Check Credit Card**

By signing below, I attest to the accuracy of the above information; I consent to evaluation and treatment; I assign all insurnace benefits for these services to *Pearson Physiotherapy Specialists, LLC.*, and I acknowledge that I have received or been offered a copy of the HIPPA Information Privacy Policy.

Signature:_____ **Date:**_____