iMotion Physical Therapy, Inc.

Patient Registration Form

Completed by: ___________________________ Date: ___________________

PATIENT INFORMATION

Last Name______________________ **First Name**______________________ **Middle Name**________________ ☐ **Male**

Street____**Apt. No.**________ **P.O. Box**__________ ☐ **Female**

City______________ **State**_____ **Zip**_______ **Home Phone**___________ **Work Phone**___________ **Cell Phone**___________

Social Sec # ___________________________**Date Of Birth**______________ **Referred By**________________________________

Email Address ____

RESPONSIBLE PARTY INFORMATION (IF PATIENT UNDER 18)

Last Name______________________ **First Name**______________________ **Middle Name**________________ ☐ **Male**

Street____**Apt. No.**________ **P.O. Box**__________ ☐ **Female**

City______________ **State**_____ **Zip**_______ **Home Phone**___________ **Work Phone**___________ **Cell Phone**___________

Social Sec # ___________________________**Date Of Birth**______________ **Email Address** _____________________________

PRIMARY CARE PHYSICIAN

Primary Care Physician____ **Tel #:** ________________________________

Address______________________________________**City**____________________**State**_____**Zip**_____________________

REFERRING PHYSICIAN

Primary Care Physician____ **Tel #:** ________________________________

Address______________________________________**City**____________________**State**_____**Zip**_____________________

PHYSICAL THERAPY
Where You Get Back In Motion

Please notify the therapist of any and all medications you are currently taking.

OFFICE USE ONLY

PRIMARY INSURANCE COMPANY INFORMATION

Company Name_________________________ **Group Name/Number** __________________ **Effective Policy Date**____/____/____

ID # ____________________________ **Co-Pay Amount** __________ **Max Physical Therapy Visits Per Year** __________________

Subscriber Last Name______________________ **First Name**______________________ **Middle Name**________________

Deductible ____________ **Co Insurance** _____________________ **Deductible Met This Year** ____________ **Effective Date** _______

Insured party must sign for all claims. Dependent patient must sign if not a minor. I certify that the information that I furnish is true and correct. I know it is a crime to fill out this form with facts that I know to be false or to leave out facts I know are important.

Initials of Patient or Legal Guardian __________ **Date:**____________