PROCarePhysical Therapy
PATIENT REGISTRATION FORM

Patient Information:

Patient Last Name: ______________________________________ First: _____________________________ MI: _______

Responsible Party (if patient under 18): _______________________________________ Relation: __________________

Address: ____ City: ______________________ State: _____ Zip: ________

Employer: ____ Occupation: ____________________________________

Home Phone: __________________________ Cell: ___________________________ Work: _________________________

Email: ____________________________________ Preferred Method of Contact☐ Home☐ Cell ☐ Work☐ Email

Date of Birth: _______________ SS #: _____________________ Gender: _________ Marital Status: ________________

Emergency Contact: __________________________________ Relation: ________________ Phone: ________________

Primary Doctor: _________________________________ Referring Doctor: ______________________________________

Health Insurance Information: **Please present your insurance card/s to the front desk to copy.**

Primary:Secondary: (if applicable)

Insurance: ____ Insurance: ____

Subscriber:____ Subscriber:____

DOB:____________________ Relationship: _____________ DOB:___________________ Relationship:________________

Is your injury work related? ☐Yes ☐No *OR* Is your injury automobile related? ☐Yes ☐No *If yes, please complete:*

Insurance Company: _________________________________ Case Manager/Adjuster: ____________________________

Phone: ______________________Claim #: _____________________Date of Injury: ___________ State of Injury:________

How did you hear about us? **☐ Internet Search ☐ My Physician ☐ Friend or Family Member**

☐ Princeton Club ☐ Gold's Gym ☐ Return Patient ☐ Workshop / Event ☐ Other ___________________

The above information is true to the best of my knowledge. I hereby authorize my insurance benefits be paid directly to PROCare Physical Therapy. I authorize PROCarePhysical Therapy to release medical information to my insurance company or third party payer as required to process my claim/s. I understand that any balance due is my responsibility regardless of insurance coverage. **I agree: _______ Patient/Guardian Initial**

MEDICARE BENEFICIARIES ONLY: I request that payment of authorized Medicare benefits be made to PROCare Physical Therapy. I authorize any holder of medical information about me to release to CMS as needed to determine these benefits or the benefits payable for services rendered. **I agree: _______ Patient/ Guardian Initial**

Patient/Guardian Signature: ____ Date: _____________________________