Patient Registration Form

Synergistic Physical Therapy

Patient Information		
Last Name:	DOB:	Age:
First Name:	Middle Initial:	Gender:
Address:	SSN#:	DL#:
City, State, Zip:	Email:	Cell:
Preferred Contact Method:	Home:	Work:

Responsible Party Information		
Last Name:	DOB:	Age:
First Name:	Middle Initial:	Gender:
Address:	SSN#:	DL#:
City, State, Zip:	Email:	Cell:
Relationship to Patient:	Home:	Work:
Employer Name & Address:		

Insurance Information		
Primary Ins:	Group #:	Policy #:
Insured Name:	Effect Date:	DOB:
Address:	SSN#:	DL#:
City, State, Zip:	Phone:	Fax:
Secondary Ins:	Group #:	Policy #:
Insured Name:	Effect Date:	DOB:
Address:	SSN#:	DL#:
City, State, Zip:	Phone:	Fax:

Parent/Legal Guardian and Emergency Contact Information	
Parent/Guardian Name:	Emergency Contact:
Address:	Address:
City, State, Zip:	City, State, Zip:
Phone:	Phone:
Patient Relationship:	Patient Relationship:

Other Information	
Was injury/illness related to work?	Date of Incident:
Was injury/illness cause by auto accident?	Date of Incident
Description of Condition:	
Referred By (Physician's Full Name):	Script Date:
Physician Address:	Physician Phone:

_____ Date: _____

Signature of Patient/Parent/Guardian

*The above information is not a guarantee of payment or certification. Payment is determined at the time the claim is received by the payor. All professional service rendered are the ultimate responsibility of the patient/insured.