

**ASCENSION PHYSICAL THERAPY
REGISTRATION FORM**
(Please Print)



Today's date:				Physician:				
PATIENT INFORMATION								
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single Mar Div Sep Wid		
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No		If not, what is your legal name?		(Former name):		Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:				Social Security no.:		Home phone no.:		
P.O. box:		City:		State:		ZIP Code:		
Occupation:		Employer:			Employer phone no.:			
Chose clinic because/Referred to clinic by (please check one box):				<input type="checkbox"/> Dr. _____		<input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital		
<input type="checkbox"/> Family		<input type="checkbox"/> Friend		<input type="checkbox"/> Close to home/work		<input type="checkbox"/> Yellow Pages <input type="checkbox"/> Online		
Other family members seen here:								

INSURANCE INFORMATION							
(Please give your insurance card to the receptionist.)							
Person responsible for bill:		Birth date:	Address (if different):			Home phone no.:	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Occupation:		Employer:	Employer address:			Employer phone no.:	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Subscriber's name:		Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: \$	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other							
Name of secondary insurance (if applicable):			Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other							

IN CASE OF EMERGENCY				
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.:	Work phone no.:
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Ascension PT or insurance company to release any information required to process my claims.				
_____			_____	
<i>Patient/Guardian signature</i>			<i>Date</i>	