Optima Physical Therapy PLLC
REGISTRATION FORM

Today's Date:	Primary Care Physician:

PATIENT INFORMATION

Patient's Last name: Patient's First Name:	Middle Initial:	Marital status:

Is this your legal name? Yes No	If not, what is your legal name?	Former name:	Date of Birth:	Age:	Sex: Male Female

Street Address:

City: State: Zip Code:

Social Security no.:	Home phone no.:	Cell phone no.:
Occupation:	Employer:	Employer phone no.:

Referred by: (Physician's name):

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Date of Birth:	Address (if different):	Home phone no.:
Is this person a patient here?	Yes No	Is this patient covered by insurance?	Yes No
Occupation:	Employer:	Employer address:	Employer phone no.:

Please indicate primary insurance: Other insurance:

Subscriber's name:	Subscriber's S.S. no.:	Date of Birth:	Group no.:	Policy no.:	Co-payment :

Patient's relationship to subscriber:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:

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 [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature Date