NEW PATIENT REGISTRATION FORM

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital Status (circle one) Single / Mar. / Div. / Sep / Wid.

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Date of Birth: / /	Age:	Sex: ❑ M ❑ F
Street Address:		Mobile phone #: ( )		Home phone #: ( )	
P.O. Box:	District:	Postal Code:		Email address:	
Occupation:	Employer:			Employer phone #: ( )	

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ________ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Referring 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 #: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone #: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Name of primary insurance:

Carrier's name:	Policyholder's name:	Birth date: / /	Group insurance #:	Policy #:	

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Carrier's name:	Group Insurance #:	Policy #:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone #: ( )	Work phone #: ( )

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 The Physiotherapy Center Ltd. or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

ASSIGNMENT OF BENEFITS

- ☐ **I AUTHORIZE** The Physiotherapy Center Ltd. to use my name on any and all claims or documents that relate to health insurance benefits due to me and my dependents.
- ☐ **I AUTHORIZE** The Physiotherapy Center Ltd. to release of any information related to any claims to all my Insurance Companies or other relevant parties.
- ☐ **I UNDERSTAND** that I am responsible for my bill and agree to pay all charges for services and items provided to me. I understand that I am responsible to pay co pays and deductibles.
- ☐ **I AUTHORIZE** payment of health benefits otherwise payable to me, directly to The Physiotherapy Center Ltd.
- ☐ **I PERMIT** a copy of this authorization to be used in place of this original.
- ☐ This "Signature on File" is valid for one year from the date indicated below.
- ☐ **I AUTHORIZE** The Physiotherapy Center Ltd. to send letters/correspondence to my physician direct from the clinic.

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Patient/Guardian signature Date