PATIENT REGISTRATION FORM

DEMOGRAPHIC INFORMATION
Patient Name: _____
Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female
Local Address: _____ City _____ Zip _____
Permanent Address: _____ City _____ State _____ Zip _____
Phone: Local _____ Cell _____ Home _____
Email: _____ SSN:_____
Emergency Contact: _____ Relationship _____ Phone _____

INSURANCE INFORMATION
Primary Insurance: _____ Secondary Insurance: _____ Policy#:_____ Policy#:_____

REFERRAL INFORMATION
Referring Physician:_____ Phone:_____
How did you hear about us? _____
If your injury was related to an accident, was it: ☐Auto Accident ☐ Work Comp ☐ Legal Proceeding Pending

EMPLOYMENT INFORMATION
Work Status: ☐ Retired ☐ Full Time ☐ Part Time ☐ Modified Duty ☐ Not Working ☐ Student ☐ Disabled
Employer: _____ Occupation: _____
Employer Address: _____

☐ **Authorization of Payment:** I hereby authorize insurance payment directly to Vitality Physical Therapy & Wellness for medical services rendered. I understand that I am financially responsible for the charges not covered by my insurance.
SIGNED Patient or Guardian _____ Date _____

☐ **Private pay:** I am electing to pay the private rate for medical services rendered. Do not bill my insurance. (not applicable for Medicare patients)
SIGNED Patient or Guardian _____ Date _____

RETURNING PATIENTS ONLY
I have reviewed and updated the above information, including the Authorization of Payment.
SIGNED Patient or Guardian _____ Date_____