Accessible Physical Therapy Services, LLC.

Registration Page 1 - Must be completed by all patients. Please Print.

Patient Last Name _____

Patient First Name _____

Patient Middle Initial _____

Social Security # _____ Date of Birth _____

Age _____ Sex: ◯ Male ◯ Female

Date of Injury _____

Cause of Injury (check one)

◯ Auto Accident

◯ Work Related

◯ Illness

◯ Other

Guardian (If patient minor) _____

Guardian Date of Birth _____

Address _____

Apartment # _____

City _____ State _____ Zip _____

Home Phone # _____

Cell Phone # _____

Employer _____ City _____ State _____ Zip _____

Employer Phone # _____

Referring Physician _____

Primary Care Physician _____

Emergency Contact _____ Relationship to Patient _____

Phone # _____

☐ **Check this box if patient does not have health insurance**

Primary Insurance Company _____

Policy # _____ Group _____

Claims Address Line1 _____

Claims Address Line2 _____

City _____ State _____ Zip _____

Policy Holder Name _____ Date of Birth _____ Relation to Patient _____

Policy Holder Social Security # _____

Secondary Insurance Company _____

Policy # _____ Group _____

Claims Address Line1 _____

Claims Address Line2 _____

City _____ State _____ Zip _____

Policy Holder Name _____ Date of Birth _____ Relation to Patient _____

Policy Holder Social Security # _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Accessible Physical Therapy Services, LLC to release any information required for processing my claims.

_____ _____

Patient/Guardian Signature Date

Office Use Only

Diagnosis _____

Location _____ Therapist _____ Reviewed By _____