pinnacle orthopaedics & sports medicine specialists

PHYSICAL/OCCUPATIONAL THERAPY REGISTRATION FORM

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status:

Is this your legal name?	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex:
❑ Yes ❑ No					

Street address:	SSN:	Home phone:

City, State, Zip:	Cell Phone:

Occupation:	Employer: (name and address)	Work Phone:

Grade Level:	School: (name and address)

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home Phone:

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Work Phone:

Primary Insurance:

Subscriber's name:	Policy #:	Subscriber DOB:	Group #:	Group Name:	Co-pay:

Patient's relationship to subscriber: ❑ Spouse ❑ Parent ❑ Legal Guardian

Secondary Insurance:

Subscriber's name:	Policy #:	Subscriber DOB:	Group #:	Group Name:	Co-Pay:

Patient's relationship to subscriber: : ❑ Spouse ❑ Parent ❑ Legal Guardian

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	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 Pinnacle Orthopaedics & Sports Medicine Specialists or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date