SOUTH ORANGE COUNTY PHYSICAL THERAPY SPECIALISTS

PATIENT REGISTRATION FORM

Last Name ____________________________ First Name & Middle Initial ________________________

Address ____ City _______________________________

State _______ Zip _____________ Phone: ___________________(H) ______________________(Cell)

Date of Birth ______________________ Sex: M / F Soc. Sec. #: _______________________________

Driver's License # ________________________________ (Mandatory)

Doctor Who Referred You to Us: _________________________ Physician Phone#: ______________________

Are you currently receiving Home Health Care? Yes / No

Did Someone Other than Your Doctor Refer You to Our Clinic? Yes / No

If Yes, may we contact that person? Yes / No. Name & Contact# of Person: ____________________________

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PERSON RESPONSIBLE FOR PAYMENT(IF DIFFERENT FROM PATIENT)

Name: ___________________________________ Occupation: ___________________________

Address: ___________________________________ City: ____________________________ Zip: ____________

Phone #: (   )__________________________ Relationship to Insured?: ___________________

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EMPLOYMENT INFORMATION (IF REQUIRED, PLEASE INDICATE MOST RECENT EMPLOYER)

EmployerName: _____________________________ Occupation: _______________________________________

Address: ___________________________________ City: ____

State: _______________ Zip: _______________ Phone: (   ) _____________________________________

Supervisor's Name: _________________________

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South Orange County Physical Therapy Specialists

STATEMENT OF FINANCIAL RESPONSIBILITY

I, ________________________, verify that my current insurance plan information as provided to South Orange County Physical Therapy Specialists is the same until further notice. I accept responsibility for any charges that may occur in the event there is a change in my coverage for the services rendered.

________________________________ ____________________
Signature of Patient Date