ADVANCED PHYSICAL THERAPY OF VIRGINIA

Registration Form

Today's Date:

PATIENT INFORMATION

Title:

- ◯ Mr.
- ◯ Mrs.
- ◯ Miss
- ◯ Ms.

Marital Status:

- ◯ Single
- ◯ Married
- ◯ Divorced
- ◯ Separated
- ◯ Widowed

Sex:

- ◯ Male
- ◯ Female

Patient's Last Name: **First:** **Middle:** **Suffix**

Social Security # : **Birth Date:** **Age:**

Street Address: **P.O. Box:** **City, State:** **Zip Code:**

Primary Phone Number: **Alternate Phone Number:** **E-mail:**

Chose clinic because / Referred to clinic by:

- ◯ Dr.
- ◯ Insurance
- ◯ Hospital
- ◯ Family
- ◯ Friend
- ◯ Location
- ◯ Yellow Pages
- ◯ Internet
- ◯ Other

Referring Physician: **Primary Care Physician:**

IN CASE OF EMERGENCY

Name of local friend or relative: **Relationship to patient:** **Home Phone No.:** **Work Phone No.:**

INSURANCE INFORMATION

Person responsible for bill: **Birth Date:** **Address (if different):**

Home Phone No.: **Condition related to:** **Occupation:**

◯ Employment ◯ Auto Accident ◯ Other

Employer: **Employer Address:** **Employer Phone No.:**

Subscriber's Name: Subscriber's SS#: **Birth Date:**

Group No.: **Policy No.:** **Co-Payment:**

Is this patient covered by insurance? **Patient's relationship to subscriber:**

◯ Yes ◯ No ◯ Self ◯ Spouse ◯ Child ◯ Other

Name of secondary insurance (if applicable):

Group No.: **Policy No.:** **Patient's relationship to subscriber:**

◯ Self ◯ Spouse ◯ Child ◯ Other

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Advanced Physical Therapy of Virginia. I understand that I am financially responsible for any balance. I also authorize Advanced Physical Therapy of Virginia or my insurance company to release any information required to process my claims

Patient / Guardian Signature: _____ **Date:** _____