PATIENT REGISTRATION INFORMATION

NAME: _____
FIRST MI LAST

BILLING ADDRESS: _____
MAILING ADDRESS – STREET OR PO BOX

_____ _____ _____
CITY STATE ZIP

PHONE: _____ _____ _____
HOME WORK CELL

BIRTHDATE: _____ AGE: _____ MARITAL STATUS: _____

OCCUPATION: _____ EMPLOYER: _____

EMERGENCY CONTACT: _____
NAME PHONE # RELATIONSHIP

REFERRING PROVIDER NAME: _____

PRIMARY PHYSICIAN: _____

Your insurance information will be collected by presenting your insurance card(s) at your first visit. Your card(s) will be scanned into your chart on our computer system.

Patients under **TRICARE,** provide SPONSOR'S SOCIAL SECURITY NUMBER: _____

Patients under **VA,** provide YOUR SOCIAL SECURITY NUMBER: _____

- **All other insurance companies**, the subscriber's social security number is optional, however, providing us with the number will help us in communicating with your insurance company should problems arise. SUBSCRIBER'S SOCIAL SECURITY NUMBER: _____

We are very glad that you are choosing First Choice Physical Therapy, Inc. for your therapy needs. Please notify our staff of any change in address, phone number, or insurance coverage as soon as changes are made. Please know that our communicating with your insurance company regarding your claims is a courtesy to you. Reimbursement of outpatient physical and occupational therapy by medical insurance companies vary with each policy. It is the patient's responsibility to be aware of their insurance coverage and maintain knowledge of that coverage. Thank you.

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