PATIENT REGISTRATION INFORMATION

NAME: ____
FIRST MI LAST

MAILING ADDRESS: ____
STREET ADDRESS OR PO BOX

______________________ __________ ______________
CITY STATE ZIP

PHONE: ______________ ______________ ______________
HOME WORK CELL

Text reminders are sent for appointments the day before your scheduled appointment,
Is it ok to text your cell #? YES or NO

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.

A social security number is optional, **HOWEVER**, providing us with it will help us in communicating with your insurance company should problems arise. For some insurances, the social security number is needed for payment so not providing us with the number, leaves you responsible for payment.

For **TRICARE** Ins, provide SPONSOR'S SOCIAL SECURITY NUMBER: ______________________

For **VETERANS/VA** coverage, provide YOUR SOCIAL SECURITY NUMBER: ______________________

For **ALL OTHER INSURANCE**, provide SUBSCRIBER'S SOCIAL SECURITY #: ______________________

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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