Orthopedic Physical Therapy Specialists, Inc.

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REGISTRATION FORM

(Please Print)

Today's Date _____/_____/_____ PCP_____

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Drivers License and State	Birth Date / /	Age	Sex ☐ M ☐ F ❑ Other

Street Address / P.O. Box	Social Security	( ) Cell Phone ( ) Home Phone

Email	City	State	ZIP Code

Occupation	Employer	Employer Phone No. ( )

Chose Clinic Because/Referred to Clinic by (Please check one box) ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital
❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other _____

Other Family Members Seen Here _____

INSURANCE INFORMATION (COPY INSURANCE CARD AND DRIVERS LICENSE)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No.
Relationship to Patient			( )

Occupation	Employer	Employer Address	Employer Phone No. ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ HIGHMARK BC ❑ AETNA ❑ CAPITAL BC ❑ MEDICARE ❑ KHPC

❑ KHP EAST ❑ United Healthcare ❑ WC ❑ AUTO ❑ CIGNA ❑ Other _____

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Name of Secondary Insurance (if applicable) Subscriber's Name	Group #	Policy #

IN CASE OF EMERGENCY

Name of Local Friend or Relative	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )