

Patient Registration for Emeryville Sports Physical Therapy

Body Part/ICD-9 Code: / /	Date of Eval:
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Patient Information Profile

Patient Status: Active <input type="checkbox"/> PFA <input type="checkbox"/>	Treating Therapist:	
Last Name:	First Name:	MI:
Address:		
City:	State:	Zip Code:
Home Phone:	Work Phone:	
Social Security#:	Date of Birth:	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other	
Driver's License #:	E-Mail Address:	
Referring Physician:	Upin:	Phone#: Fax#

Insurance Information/Responsible Party

Primary Insurance:		
Address:		
City:	State:	Zip Code
Insured Person's Name:	Relationship to Patient:	
Subscriber/PolicyNumber:	Group Number:	Network <input type="checkbox"/> In-Net <input type="checkbox"/> Out-Net
Insurance Phone#:	Fax Number:	
Adjuster or Claims Representative:	Phone Number:	

Patient's Employer Information

Employer Name:	Phone Number:	
Employer Address:	State:	Zip Code:

Emergency Contact Information

Last Name:	First Name:
Phone Number:	Relationship to Patient:

Other Information

Date of Injury:	Date of Surgery:	Accident: <input type="checkbox"/> None <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Other
Description of Injury:		

Patient Certification and Signature

I certify that all of the information provided above is true and correct. I authorize the clinic and its affiliates to release information to my insurance company if required to expedite payment. I authorize payment directly to Emeryville Sports PT and understand that my insurance company is being billed as a courtesy to me. I also understand that my benefits are being verified but are not a guarantee of coverage. If the information provided by my insurance company is not accurate or the coverage changes, I will be responsible for payment on all services not paid.

Patient/Guardian Signature:	Date:
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******Internal Office Use Only******

Effect. Date:	Coverage: %	Co-Ins: %	Co-Pay: \$	Pre-Cert: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Visits per year:	Visits Used:	Cal. Year:	Fiscal Year:	From-To:	Ded. Start Amount.: \$	Amount Remaining: \$
Benefits Verified By:		Date:		Spoke To:		
Secondary Insurance:	Address:		Name of Subscriber:			
Subscriber/PolicyNumber:	Relation to Patient:	Date of Birth:	Group Number:	<input type="checkbox"/> In-Net <input type="checkbox"/> Out-Net		
Effect. Date:	Coverage: %	Co-Ins/Co-pay:	Visits per yr:	Comments:		