



PATIENT REGISTRATION

Patient Name: _____
First MI Last

Birthday: _____ SSN: _____ Sex: _____ M _____ F

Home Phone: _____ Cell Phone: _____

Home Address: _____
Street City State Zip

Marital Status: _____ Email: _____

RESPONSIBLE PARTY

Mother's/Guardian's Name: _____ Father's/Guardian's Name: _____

Address: _____ Address: _____
(if different than patient's) (if different than patient's)

Cell #: _____ Work #: _____ Cell #: _____ Work #: _____

Employer: _____ Employer: _____

INSURANCE INFORMATION

Primary Insurance Plan _____ ID: _____ Group: _____

Policy Holder Name: _____ Relationship to patient: _____

Policy Holder SSN: _____ Policy Holder Birthdate: _____

Secondary Insurance Plan _____ ID: _____ Group: _____

Policy Holder Name: _____ Relationship to patient: _____

Policy Holder SSN: _____ Policy Holder Birthdate: _____

EMERGENCY CONTACT

Name: _____ Relationship to patient: _____

Address: _____ Phone #: _____

AUTHORIZATIONS: I authorize the following person(s) to bring my child in for appointments. I also give permission to release treatment, future recommendations, and any related therapy information to said authorized person(s):

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE OF INFORMATION AND AUTHORIZATION FOR TREATMENT.

Please read and sign below:

I hereby authorize evaluation/treatment by Southeastern Physical Therapy Inc./Spectrum Physical Therapy/Southeastern Therapy for Kids on behalf of myself and/or my minor child, including stepchild. I understand that all fees or charges as a result of my visits are payable at the time of professional services given. I authorize my insurance carrier, if applicable, to pay for these services for me. I agree to pay for charges not covered by insurance. I authorize Southeastern Physical Therapy/Spectrum Physical Therapy / Southeastern Therapy for Kids to release to my medical insurance company any information about my care should they request my information.

Patient/Parent Signature: _____ Date: _____

Witness: _____ Date: _____