

**INTEGRATIVE PHYSICAL THERAPY SERVICES
PATIENT REGISTRATION FORM**

Last Name: _____ **First** _____ **M.I.** _____ F M

Home address _____ City, St _____ Zip _____

Phones: Home _____ Work _____ Cell _____

E-mail (*print as legibly as possible*) _____

Social Security _____ DOB _____ Age _____

Employer _____

Marital Status _____ Spouse's Name _____ Spouse's DOB _____

Name of Primary Insurance: _____

Policy Number _____ Group Number _____

Policy Holder Name _____ Policy Holder DOB _____

Policy Holder Employer _____

Name of Secondary Insurance: _____

Policy Number _____ Group Number _____

Policy Holder Name _____ Policy Holder DOB _____

Policy Holder Employer _____

Referring Physician: _____

Reason For Today's Visit _____ Date of Surgery Injury

Emergency Contact Name: _____ Relationship _____

Address _____ Phone _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Integrative Physical Therapy Services (IPTS). I understand that I am financially responsible for any balance. I also authorize IPTS or insurance company to release any information required to process my claims. I hereby consent to treatment by authorized personnel of Integrative Physical Therapy Services as may be dictated by my illness, injury or condition. This consent is intended as a waiver of liability for such treatment except for acts of negligence.

Patient Signature

Date

Signature of Responsible Person (if patient is a minor)

Date