



Committed to **EXCELLENCE** in  
Physical Therapy & Sports Rehab

## Patient Registration

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
E-mail \_\_\_\_\_

Employer \_\_\_\_\_  
Occupation \_\_\_\_\_  
If Student, Name of school \_\_\_\_\_ Grade \_\_\_\_\_  
Activities/Sports \_\_\_\_\_

Referring Physician/Coach/Trainer \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

### Insurance Information: (If physician referred and prescription obtained)

Was Injury a result of an accident? \_\_\_\_\_ If yes: Job related? YES NO  
Auto \_\_\_\_\_ Other \_\_\_\_\_ Date of Injury or onset: \_\_\_\_\_  
Insurance Company Name: \_\_\_\_\_  
Billing Address: \_\_\_\_\_  
ID/Group Number: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name of Insured : \_\_\_\_\_ Relationship to you \_\_\_\_\_

I hereby authorize the release of medical information necessary to process my insurance claim. This may include intake forms, chart notes, reports, correspondences, billing statements and any other information to my attorneys, health care providers and insurance case managers.

I am responsible for all charges for all services provided. In the event that the insurance company denies benefits or makes a partial payment, I am responsible for any balance due. This may not apply to insurance companies that I am under contract with.

I understand the benefits and risks of treatment and give my consent for treatment. I will consult my practitioner with any questions or concerns immediately.

Signature \_\_\_\_\_ Parent/Guardian (if under 18) \_\_\_\_\_

Date \_\_\_\_\_

830 Distribution Drive, Beavercreek, Ohio 45434 Phone 431-0300 Fax 431-9100