

WALLACE PHYSICAL THERAPY
PATIENT REGISTRATION FORM
(PLEASE PRINT)

Patient Full Name: _____ Responsible Party: _____

Mailing Address: _____ City, State, Zip: _____

Perm Addr if different: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Sex: M F D.O.B. _____

Age: _____ Patient SSN # ____/____/____ Referring Dr: _____

Responsible Party SSN: _____ Relationship to patient: _____ (self, spouse, child)

Emergency contact: Name/Addr/Phone: _____

Injured on the job? Y N Date of injury: _____ Personal Injury? Y N

If Personal Injury Name/ Addr/ Phone of Attorney: _____

Insurance Information

If you have your insurance card, you don't need to complete the insurance section below. Please give your insurance card to the office staff to copy. If not available, fill out information below.

Primary or Industrial Insurance

Insurance Co. Name: _____

Policyholder's Name: _____

Rel. To Patient: _____ Copay \$: _____

Policyholder's sex: M F D.O.B: _____

Policy#: _____ Group/Claim #: _____

Insurance Effective Date: _____

Secondary Insurance

Insurance Co. Name: _____

Policyholder's Name: _____

Rel to Patient: _____ Copay \$ _____

Policyholder's sex M F D.O.B: _____

Policy#: _____ Group/Claim #: _____

Insurance Effective Date: _____

Authorization to release information: I hereby authorize the release of any medical information necessary to process my claims. In the event that a dispute arises regarding non-payment for services between my doctor and my insurance company, I give my permission for the Az department of Insurance to access my medical records if necessary to resolve the matter. I also authorize my insurance benefits be paid to Robert Wallace Physical Therapy. I understand that I am financially responsible for non-covered services.

Signed: _____

Date: _____