



PT by the Sea, Inc.

REGISTRATION FORM

PATIENT INFORMATION

Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name? (Former name):		Birth date: / /		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Street address:			Social Security no.:		Home Phone() Work/Cell ()		
P.O. box:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone no.()		
Chose clinic because/Referred to clinic by (please check one box): <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Close to home/work				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital	
<input type="checkbox"/> Yellow Pages				<input type="checkbox"/> Other			
Other family members seen here:							

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:		Birth date: / /	Address (if different):		Home phone no.: ()			
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Occupation:		Employer:		Employer address:		Employer phone no.: ()		
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Please indicate primary insurance		<input type="checkbox"/> [Insurance]						
Subscriber's name:		Subscriber's S.S. no.:		Birth date: / /	Group no.:		Policy no.:	Co-payment: \$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other			
Name of secondary insurance (if applicable):			Subscriber's name:			Group no.:		Policy no.:
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other			

INJURY INFORMATION

Was this injury the result of an auto accident? <input type="checkbox"/> yes <input type="checkbox"/> no				Driver's License #			
State in which the accident occurred:				Unable to work from :		to:	
Worker's Compensation? <input type="checkbox"/> yes <input type="checkbox"/> no		Occupation:		Employer:			
Medicare Patients Only: Are you presently receiving or are you eligible to receive home health care services? <input type="checkbox"/> yes <input type="checkbox"/> no							

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):		Relationship to patient:		Home phone no.: ()		Work phone no.: ()	
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to PT by the Sea, Inc. I understand that I am financially responsible for any balance. I also authorize PT by the Sea or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date