PATIENT REGISTRATION INFORMATION

PLEASE PRINT CLEARLY

Patient's Name_____ **Male / Female**
LAST FIRST M.I. CIRCLE

Patient's Birth Date_____ **E-Mail** _____
MONTH/DATE/YEAR

Address_____
STREET CITY ZIP

Home Phone_____ **Cell Phone**_____

Referring Physician_____

Parent/Guardian_____

Primary Insurance_____
Insurance Company Name Subscriber ID Number

Insured's Name_____ **Birth Date**_____
MM/DD/YYYY

Relationship_____

Secondary Insurance_____
Insurance Company Name Subscriber ID Number

Insured's Name_____ **Birth Date**_____
MM/DD/YYYY

Relationship_____

Who may I thank for referring you?_____

Accident? Yes/No **If yes, date of accident**_____

If yes, Automobile/Work/Other_____

I hereby irrevocably authorize payment of medical services rendered to myself or my dependent(s) directly to Blooming Steps Physical Therapist. I also authorize same to furnish my insurance with full information regarding treatment rendered to me or my dependent(s). I also understand that my insurance is billed as a courtesy, and that I am responsible for all charges not paid by my insurance company within six weeks after the billing date.

_____ _____
PLEASE SIGN DATE