REGISTRATION FORM

Today's Date:

PATIENT INFORMATION

Patient's last name: First: Middle: ☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. Marital status (circle one) Single / Mar / Div / Sep / Wid

Birthdate: / / Age: Sex: ☐ M ☐ F

Mailing Address: Preferred Phone: Alternate Phone: Social Security No.:

City: State: Zip:

Email:

Employer:

How did you find Core Physical Therapy? (please check one box):

☐ Dr. _____ ☐ Existing/Former Patient: _____ ☐ Family/Friend:_____

☐ Website ☐ Google Search ☐ Hummingbird ☐ Instagram ☐ Facebook

☐ Other _____

Person responsible for bill: Birthdate: / / Address (if different):

Phone:

Employer: Employer Address: Employer Phone:

Is this patient covered by insurance? ☐ Yes ☐ No

(Please give your insurance card(s) to the receptionist)

INSURANCE INFORMATION

Please indicate **primary** insurance:

Policy No.: Group No.:

Subscriber Legal Name: Social Security No.: Birthdate: / /

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Does this patient have another insurance? ☐ Yes ☐ No

Legal Name of Other Subscriber: Social Security No.: Birthdate: / /

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Please indicate **secondary** insurance:

Policy No.: Group No.:

Emergency Contact

Name of local friend or relative: Relationship to patient:

Home phone: Cell phone:

Reviewed 2/28/2024