## Center for Physical Therapy & Sports Medicine

# 3920 Springfield Rd 1011 Hioaks Rd ste. a Glen Allen, va 23060 richmond, va 23225

# *REGISTRATION FORM*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| (Please Print) | | | | | | | | | | | | | | | | | | |
| PATIENT INFORMATION | | | | | | | | | | | | | | | | | | |
| Last name: | | | | | | | First: | | | | Middle: | | | ❑ Male  ❑ Female | | Marital status (circle one) | | |
|  | | | | | | | | | | | | | | Single / Mar / Div / Sep / Wid | | |
| Home phone no.: | | | | |  | | | | Cell phone no.: | | | | | | | Birth date: | Age: | |
| ( ) | |  | | |  | | | | ( ) | | | | | | | / / |  | |
| Street address: | | | | | | | | | | | | |  | | | Social Security no.: | | |
|  | | | | | | | | | | | | |  | | |  | | |
| P.O. box: | | | | City: | | | | | | | | | | | | State: | ZIP Code: | |
|  | | | |  | | | | | | | | | | | |  |  | |
| Email: | | | |  | | | | | | | | | | | | Would You Like To Be Sent Appointment Reminders To Your Email: | | |
|  | | | |  | | | | | | | | | | | | Yes No | | |
|  | | | | | | | | | | | | | | | | | | |
| Physicians | | | | | | | | | | | | | | | | | | |
| Referring Physician: | | | | | | | | | | | | Primary Care Physician: | | | | | | |
|  | | | | | | | | | | | |  | | | | | | |
| Check here if you **do not** want reports sent to your PCP | | | | | | | | | | | | |  | | |  | | |
|  | | | | | | | | | | | | |  | | |  | | |
| INSURANCE INFORMATION | | | | | | | | | | | | | | | | | | |
| Patient’s relationship to subscriber: Self Spouse Child Other | | | | | | | | | | | | | | | | | | |
| Guarantor’s Name (unless self) | | | | | Birth date: | | | | | Address (if different): | | | | | | Home phone no.: | | |
|  | | | | | / / | | | | |  | | | | | | ( ) | | |
| Occupation: | | | Employer: | | | | | Employer address: | | | | | | | | Employer phone no.: | | |
|  | | |  | | | | |  | | | | | | | | ( ) | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| Emergency Contact: | | | | | | Relationship to patient: | | | | | | | Home phone no.: | | | | Work phone no.: | |
|  | | | | | |  | | | | | | | ( ) | | | | ( ) | |
| The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Center for Physical Therapy & Sports Medicine or the insurance company to release any information required to process my claims. | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | |  |  | |  |
|  | Patient/Guardian signature | | | | | | | | | | | | | |  | Date | |  |