## Center for Physical Therapy & Sports Medicine

# 3920 Springfield Rd 1011 Hioaks Rd ste. aGlen 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 |  |