INSIGHT PHYSICAL THERAPY & YOGA REGISTRATION FORM

(Please Print)

Today's date:			PCP:	
PATIENT INFORMATION				
Patient's last name: First: MI:			Birthdate:	
Street address:	City:	State:	Zip Code:	
Marital status (circle one) Single / Married / Other	Sex: ❑ Male ❑ Female	Cell phone no: ❑ Preferred ( )	Home/Alt. phone no.: ❑ Preferred ( )	
Email address:	Employer:			
Referring provider:	Address:	Phone no.: ( )		
INSURANCE INFORMATION				
(Please provide a copy of your insurance card.)				
Primary Insurance:	ID #:	Group #:		
Subscriber's name:	Birthdate: / /	Sex: ❑ Male ❑ Female	Phone no.: ( )	
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other				
Customer service phone no.: ( )	Insurance billing address:	Employer:		
Name of secondary insurance (if applicable):	ID #:	Group #:		
Subscriber's name:	Birthdate: Sex: ❑ M ❑ F	Insurance billing address:	Customer service phone no.: ( )	
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other				
IF ACCIDENT RELATED:				
Date of accident:	How it happened: ❑ Work ❑ Auto ❑ Other _____			
Insurance company:	Claim #:			
Address:				
Claims adjuster:	Phone no:			
Attorney:	Phone no:			
IN CASE OF EMERGENCY				
Name of local friend or relative:	Relationship to patient:	Primary 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 Insight Physical Therapy & Yoga or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*