REGISTRATION

Date_____ **Home Phone**_____

Patient_____
Last Name **First Name** **Initial**

Street Address_____

City_____ **State**_____ **Zip**_____

Sex ☐**M**☐**F** **Age**_____ **Birthdate**_____☐**Single** ☐**Married** ☐**Widowed** ☐**Separated**☐**Divorced**

Social Security #_____

Insured's Name _____

Relationship to Insured ☐**Self** ☐**Spouse** ☐**Child** ☐**Other**

Condition Related to ☐**Illness** ☐**Employment** ☐**Auto** ☐**Other**

EMPLOYER	Company Name _____Occupation_____ Address_____Phone_____ City_____State_____Zip_____
SPOUSE	Name_____ Last Name First Name Initial Birthdate_____Social Security #_____ Employer Name_____Occupation_____ Address _____Phone_____ City _____State_____Zip_____
PATIENT INSURANCE AND LEGAL INFORMATION	**Please provide primary and secondary insurance cards to receptionist for photocopying. If motor vehicle accident, please provide automobile insurance declarations page.** If Motor Vehicle Accident or Worker's Compensation Date of Accident_____ Insurance Company Name _____Adjuster_____ Address/Phone_____Claim #_____ Policy #_____Effective Date_____ Attorney Name:_____ Address/Phone:_____
MEDICAL INFORMATION	Referred by_____ Present Complaint_____ Known Medical Problems_____ _____ Pregnant ☐Yes ☐No Pacemaker ☐ Yes ☐No Family Physician_____ Person to contact in emergency (Name and Phone #)_____
PATIENT AGREEMENT	ASSIGNMENT AND RELEASE I, the undersigned, have insurance coverage with _____and Name of insurance company assign directly to **Quinnipiac Physical Therapy and Sports Medicine, P.C.** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize **Quinnipiac Physical Therapy & Sports Medicine, P.C.** to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. _____ _____ Signature of Insured/Guardian Date