



Registration Form

(Please Print Clearly)

PATIENT INFORMATION

TODAY'S DATE: / /		PRIMARY CARE PHYSICIAN:			
Patient's Last Name		First	Middle	How would you like to be addressed?	
Street Address		City		State	Zip Code
Home Phone	Work Phone (extension)	Cell Phone	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Date of Birth / /
Email Address:					
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		Employment Status <input type="checkbox"/> Full <input type="checkbox"/> Part <input type="checkbox"/> Retired <input type="checkbox"/> Not Employed <input type="checkbox"/> Other		Accident? <input type="checkbox"/> None <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Other	
				Date Of Next Physician Appt / /	

INSURANCE INFORMATION (Please Show Your Insurance Cards)

Primary Insurance	Policy Holder Name	Policy Holder DOB	Insurance Card ID #	Group #
Co-Payment \$ _____	Patient Relationship To Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____			
Secondary Insurance	Policy Holder Name	Policy Holder DOB	Insurance Card ID #	Group #
Co-Payment \$ _____	Patient Relationship To Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____			

IN CASE OF EMERGENCY

Contact Name	Relationship To Patient	Home Phone	Work Phone
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The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Onondaga Physical Therapy, LLC. I understand that I am financially responsible for any balance unpaid by my insurance company. I authorize Onondaga Physical Therapy, LLC and my insurance company to release any information required to process my claims.

I hereby consent to treatment procedures and patient care which in the judgment of my therapist and/or physician may be considered necessary or advisable while I am a patient of Onondaga Physical Therapy, LLC.

I hereby authorize the use or disclosure of my individually identifiable health information as described in the NOTICE OF PRIVACY PRACTICES I received.

Onondaga Physical Therapy reserves the right to charge \$30 for any "No Show" or appointments cancelled without 24 hours prior notice.

X _____ DATE
 PATIENT/GUARDIAN SIGNATURE