New Patient Registration & Personal Information

Last Name/First Name: _____

Address: _____ Apt.: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____Work: _____ Cell: _____

E-mail: _____ Referring Physician: _____

Social Security: _____ Marital Status: _____ Married _____ Single

Sex: ____ Male ____ Female Date of Birth: _____ Referred By: _____

In case of emergency contact: _____ Phone#: _____

Insurance Information:

Name of Insured: _____ Policy#: _____

Insurance Carrier: _____ Phone# _____

Relationship to Insured: _____ Self _____ Spouse _____ Child/Financial Dependent Date-of-birth:__/___/___

Responsible Party (If different from above):_____ Phone: _____

Employment Information:

Employer: _____

Address: _____

I hereby assign all rights, privileges and remedies to payment for health care services to John Iathrop PT I also authorize John Lathrop PT, having treated me, to release to government agencies, insurance carriers and all others who are financially liable for my care, all information needed to substantiate payments for care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment. I have read and understand the privacy practices of the office.

Patient Signature: _____ Date: _____