New Patient Registration & Personal Information

Last Name/First Name: _____

Address: _____ Apt.: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____Work: _____ Cell: _____

E-mail: _____ Referring Physician: _____

Marital Status: ____ Married _____Single Sex: ____ Male ____ Female

Date of Birth: _____ Social Security: _____

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: _____

I hereby assign all rights, privileges and remedies to payment for health care services to John Lathrop Physical Therapy PLLC. I also authorize JLPT PLLC, 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. You may receive informational emails from JLPT. I have read and understand the privacy practices of the office.

Patient Signature: _____ Date: _____