[Form NP!-3 rev.12/16]

SUMMERVILLE PHYSICAL THERAPY & Balance Rehabilitation for Adults

# NEW PATIENT REGISTRATION/ INSURANCE

Today's Date

NAME

HOME ADDRESS

CITY STATE ZIPCODE

BILLING ADDRESS (if different from above address)

ADDRESS

CITY STATE ZIPCODE

PHONE (Please check the number you prefer to be called at)

HOME ( ) CELL ( ) WORK ( )

| SEX | AGE | DATE OF BIRTH |
|---|---|---|
| ☐ MALE ☐ FEMALE | | |

REFERRED BY (NAME)

☐ DOCTOR_____

☐ FRIEND_____

☐ OTHER_____

MARITAL STATUS

☐ SINGLE
☐ MARRIED
☐ SEPARATED
☐ DIVORCED
☐ WIDOWED

## EMERGENCY CONTACT INFORMATION

| NAME | RELATION TO PATIENT |
|---|---|
| PHONE | ALTERNATIVE PHONE |

SUMMERVILLE PHYSICAL THERAPY & Balance Rehabilitation for Adults

| PRIMARY INSURANCE | | | |
|---|---|---|---|
| Company Name | Insured's Name | Plan ID | Policy # |
| | | | |
| **SECONDARY INSURANCE (if applicable)** | | | |
| Company Name | Insured's Name | Plan ID | Policy # |
| | | | |

## WORKERS COMPENSATION/ACCIDENT INFORMATION (if applicable)

| MOTOR VEHICLE ACCIDENT ☐ YES ☐ NO | WERE YOU INJURED ON THE JOB? ☐ YES ☐ NO | DATE OF INCIDENT | CLAIM NUMBER |
|---|---|---|---|
| | | | |
| NAME OF INSURANCE CARRIER | | PHONE | FAX/EMAIL |
| | | | |
| CLAIMS ADJUSTER | | PHONE | FAX/EMAIL |
| | | | |
| NURSE CASE MANAGER | | PHONE | FAX/EMAIL |
| | | | |

All services furnished are charged directly to the patient. Patients are financially responsible for payment unless other arrangements have been made with the office management. It is our policy that payment be made at the same time services are rendered. We do not render services on the basis that insurance companies are financially responsible.

**CONSENT FOR TREATMENT**

I hereby authorize my consent to be treated now and in the future by Summerville Physical Therapy and Balance Rehabilitation for Adults, signed by:

| PATIENT / INSURED SIGNATURE | DATE |
|---|---|
| | |