PATIENT REGISTRATION

Last name_____ First name_____ Middle I._____
Address_____
City_____State_____Zip Code_____
SS#_____Birthdate_____Age____Marital Status_____
Home Phone_____Work Phone_____Cell Phone_____
Email_____Occupation_____
Employer_____
Doctor_____Doctor Phone #_____
Chief complaint/Diagnosis_____
Who may we thank for referring you?_____
In case of emergency, Please contact_____Relationship_____
Phone # of contact person_____

Responsible Party if different from Patient:

Name_____Phone_____
Address_____
City_____State_____Zipcode_____
Employer_____

Insurance Information:

(This office offers the courtesy of Insurance Billing, however,we do not have a contract with all companies.)

Is this an on the Job Injury?_____Claim#_____Date of Injury_____
Claim Manager_____Phone # _____

Is this a Motor Vehicle Accident?____Claim #_____Date of Accident_____
Insurance Co_____Claim Manager_____
Phone #_____Address_____

Private Insurance_____
Billing Address_____
Phone #_____Subscriber Name_____Birthdate_____
Identification #_____Group#_____

I the undersigned certify that I or my dependent have insurance coverage with the above listed insurance and assign directly to Kay Lakey Physical Therapy/Kay Lakey RPT, all insurance benefits. I understand that I am financially responsible for all deductibles, non-covered services, or non-authorized services. I also authorize Kay Lakey Physical Therapy to release medical and billing information to my physician or insurance company if requested.

Signature of Insured/Guardian Date