REGISTRATION FORM

Please Print

Referred by: _____ ***Date***: _____

Patient Name: _____ ***SSN***: _____

First *Last*

Street Address: _____

City: _____ ***State***: _____ ***Zip Code***: _____

Present Employer:_____***Work Phone:(____)***_____

Date of Birth: ____/_____/_____ ***Sex****(circle one) M F* ***Marital Status****(circle one) M S D W*

Cell Phone(_____)_____ ***Home Phone(_____)***_____

Emergency Contact: _____ *Home/Cell #* _____

INSURANCE INFORMATION

Spouse or Parent: _____ ***Date of Birth***: ____/_____/_____

Primary Insurance:_____ *(**Circle one**) Self Spouse Parent*

Secondary Insurance:_____ *(**Circle one**) Self Spouse Parent*

Do you have a co-pay? (circle one) Yes No If yes, how much? _____

Is this related to a work accident? (circle one) Yes No

Is this related to an automobile accident? (circle one) Yes No

Do you want a copy of our Notice of Privacy Practices? (circle one) Yes No

I voluntarily give consent and permission for Cumberland Physical Therapy and its licensed therapists to administer medically necessary physical therapy services.
Signature: _____ Date: _____

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Cumberland Physical Therapy. I acknowledge that I am financially responsible for payment whether or not covered by insurance.
Signature: _____ Date: _____