

# Suburban Physical Therapy REGISTRATION INFORMATION

**PATIENT INFORMATION:** Please print all information

LAST NAME	FIRST NAME	MIDDLE INITIAL	AKA	SOCIAL SECURITY #
STREET ADDRESS		CITY	STATE	ZIP CODE

E-MAIL ADDRESS: \_\_\_\_\_

BIRTHDATE	AGE	SEX	MARITAL STATUS	OCCUPATION	HOME PHONE # ( ) Contact <input type="checkbox"/> Yes <input type="checkbox"/> No	BUSINESS PHONE # ( ) Contact <input type="checkbox"/> yes <input type="checkbox"/> No
EMPLOYER			EMPLOYER ADDRESS		GROUP HEALTH INS. WITH EMPLOYER <input type="checkbox"/> YES <input type="checkbox"/> NO	

How did you hear about our office:  Physician  Family/Friend  Insurance  Phone Book  
 Internet  Other \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_  
Have you previously received physical therapy? Yes No/ If Yes when \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION:** (Person assuming financial responsibility for account.)

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY #	RELATIONSHIP TO PATIENT		
STREET ADDRESS		CITY	STATE	ZIP CODE		
BIRTHDATE	AGE	SEX	MARITAL STATUS	OCCUPATION	HOME PHONE # ( ) Contact <input type="checkbox"/> Yes <input type="checkbox"/> No	BUSINESS PHONE # ( ) Contact <input type="checkbox"/> Yes <input type="checkbox"/> No
EMPLOYER			EMPLOYER ADDRESS			

**BILLING INFORMATION:**

1. I authorize the above provider to release my medical/financial information to my insurance, third party payor or this provider's collection agents, attorneys and consultants necessary to pay for services rendered. I also know that I am responsible for deductibles, co-insurance and any services not covered by my insurance. If the patient is a minor, I as a parent/guardian authorize treatment. If uninsured, I will be responsible for all charges at the time of the visit. I further authorize all payments to be made directly to this provider.

DATE \_\_\_\_\_  
Signature of Patient/Responsible Party

2. I understand that I am primarily responsible for payment of all charges/services rendered regardless of the status of my claim before the Bureau of Workers Compensation. I authorize release of any medical/financial records to insurance, caseworkers, third party payors or this provider's collection agents, attorneys and consultants necessary to obtain payment for services rendered. I further authorize all payments directly to this provider.

DATE \_\_\_\_\_  
Signature of Patient/Responsible Party





# Suburban

Physical Therapy  
& Sports Medicine

## MEDICAL HISTORY FORM

Name \_\_\_\_\_ Date \_\_\_\_\_

List any allergies you have to drugs, food or other items:

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List major operations:

Operation Performed	Year
_____	_____
_____	_____
_____	_____

(Female Patients): Are you currently pregnant: (Please Circle)      Yes      No

Have you had any of the following illnesses: (Please Circle)

- |                          |                   |                      |
|--------------------------|-------------------|----------------------|
| Diabetes                 | Heart Disease     | Rheumatoid Arthritis |
| High Blood Pressure      | Heart Attack      | Osteoarthritis       |
| Low Blood Pressure       | Chest Pain/Angina | Asthma               |
| Congestive Heart Failure | Cancer            | Seizures             |
| COPD/ Lung Disease       | Stroke            | Hepatitis            |
| Osteoporosis/Osteopenia  |                   |                      |

Other serious illnesses: (Please Explain): \_\_\_\_\_

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