Peak Rehabilitation, Fitness and Performance Center, LLC

PATIENT REGISTRATION FORM

Date: _____

Patient Information

Patient's Full Name (First, MI, Last): _____

Sex: Male _____ Female _____

Date of Birth: _____ Age: _____ Married _____ Single _____ Other _____

SSN: ___ - ___ - ___

Mailing Address: _____

City / State / Zip: _____

E-Mail Address: _____

Telephone: Home: _____ Cell: _____ Work: _____

Full Time Student _____ Part Time Student _____ Employed _____ Retired _____ N/A _____

Employer: _____

Occupation: _____

Work Address: _____

City / State / Zip: _____

Spouse or Parent's Information (provide guardian or **both parent's information** if patient is a minor)

Name: _____ DOB: _____ SSN: _____

Relationship to Patient: Spouse _____ Mother _____ Father _____

Employer: _____

Occupation: _____

Work Address: _____

City / State / Zip: _____

Case Information

Referring Physician: _____ Date last seen: _____

Primary Care Physician: _____

Condition Related To: Employment _____ Accident _____ Other _____

Date of Accident or Onset of Symptoms: _____

Primary Complaint or Injury: _____

Involved Side: R _____ L _____ Dominant Side: R _____ L _____

Date of Surgery: _____

Primary Insurance Information

Name of Primary Insurance: _____ Insured Name: _____

Policy #: _____ Insured DOB: _____

Group #: _____ Insured SSN: _____

Relationship to Patient: Self _____ Spouse _____ Parent _____

Please complete both sides of form

Peak Rehabilitation, Fitness and Performance Center, LLC
PATIENT REGISTRATION FORM

Employer's Name and Address: _____

Secondary Insurance Information

Name of Secondary Insurance: _____ Insured Name: _____

Policy #: _____ Insured DOB: _____

Group #: _____ Insured SSN: _____

Relationship to Patient: Self _____ Spouse _____ Parent _____

Employer's Name and Address: _____

Worker's Compensation Claims: Please see front desk to be sure all information has been acquired

I consent to treatment and I authorize Peak Rehabilitation, Fitness and Performance Center, LLC to release to any insurance company or government agency any and all information necessary to process my insurance claims. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any charges not covered by my insurance. I permit a copy of this authorization to be used in place of the original.

Signature: _____ Date: _____