Patient Registration

Please Complete All

Date / /	Therapist

Patient Name Last First Initial	Marital Status ☐S ☐M ☐D ☐W	Sex ☐M ☐F

Home Address	City, State, Zip	Telephone

Employer Name	Employer Address	Work Telephone

Occupation	Social Security Number	Date of Birth / /	Age	Email Address

Spouse or Parent Name	Employer's Name and Address	Work Telephone

Name of Financially Responsible Person (if Different from Patient) ☐ Spouse ☐ Parent ☐ Other

Address (if Different from Patient)	Date of Birth	Social Security Number
Employer Name and Address	Telephone	Work Telephone

Primary Health Insurance Co. Name	Policy Holder	Policy Holder's Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other

Insurance Co. Address (not necessary if card was copied)	ID/Policy No.	Group No.	Policy Holder DOB	Effective Date / /

Secondary Health Insurance Co. Name	Policy Holder	Policy Holder's Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other

Insurance Co. Address (not necessary if card was copied)	ID/Policy No.	Group No.	Policy Holder DOB	Effective Date / /

Referring Physician	Any Member of Family Treated by Our Group Before? If so, please list name(s). ☐ Yes ☐ No

Emergency Contact	Relationship to Patient	Telephone

Your Current Problem: Work Related? ☐ Yes ☐ No Auto Accident? ☐ Yes ☐ No Other Accident? ☐ Yes ☐ No

Date of Injury/Accident / /	Brief description of accident:

Employer at Time of Injury	Address	Telephone

Description of Injury:

Workers' Compensation Insurance Carrier (Please note that we accept Wyoming Worker's Compensation ONLY)	Claim Number

Case Worker's Name	Telephone

Is Attorney Assisting You With This Claim? ☐ Yes ☐ No

Attorney's Name	Address	Telephone

AUTHORIZATION AND RELEASE:

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to my attorney, third party payers, and/or other health practitioners. **I authorize and request my insurance company to pay Gillette Physical Therapy directly for services rendered and billed by them.** I understand that the filing of insurance claims is a courtesy of Gillette Physical Therapy. I remain fully responsible for any charges incurred. I further agree that understanding my insurance benefits is my responsibility. Should I have any questions regarding my insurance my best avenue is calling my insurance company benefits department. I agree to be fully responsible for any fees incurred to collect any outstanding balance up to and including interest charges (up to 10%) and any court/sheriff fees used in attempt to collect any overdue debt. I understand that payment of copays/coinsurance may be requested to be paid prior to the full processing of my insurance claims. I authorize for detailed messages to be left on the phone numbers provided, unless noted otherwise. I further understand that the issuing of credit pending insurance payment is a courtesy and at the full discretion of Gillette Physical Therapy as payment is expected at the time service is rendered.

Signature of Patient/Legal Guardian if Minor Date