Date of Injury: _____

PATIENT REGISTRATION DATA

Date: _____

Patient Last Name: _____ First Name: _____ MI: _____

Soc. Sec. #: _____ Birth Date: _____ Age: _____ Sex: _____ Marital Status: _____

Street Address: _____ City: _____

State: _____ Zip: _____ ☐ Home Telephone: _____ Driver's License #: _____

Employer: _____ Address: _____

☐ Work Telephone: _____ Occupation: _____

☐ Cell Phone: _____ ☐ E-mail address: _____

Nearest Relative: _____ Telephone: _____ Relationship: _____

Responsible Party (If Patient is Minor)

Last Name: _____ First Name: _____ MI: _____

Soc. Sec. #: _____ Street Address: _____

City: _____ State: _____ Telephone: _____ Relationship: _____

How did you hear about CCPT? _____

If referral, who were you referred by? _____

☐ **Please check the box next to the daytime telephone number or e-mail address that you prefer to be contacted with.**

☐ **Please check this box if you would <u>not</u> like to receive our educational newsletter via email.**

Attention:

As a courtesy to our patients, Century City Physical Therapy, Inc. has contacted your insurance company to assist you in understanding your physical therapy insurance benefits. ***This is only an <u>estimate</u> of what your insurance company has quoted to CCPT and by no means is a guarantee that this will be carried out by your insurance company.*** We advise you to double check with your insurance company to avoid any miscommunication. Thank you.

Insurance Carrier: _____ In Network/Out of Network

Deductible Met: _____ Deductible Not Met: _____ Coverage: _____

Limits: _____

Patient Signature: _____

Date: _____