



Registration

Date: \_\_\_\_\_

Last: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Male  Female Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Marital Status:  Single  Married  Other \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Reminder call:  Home  Cell  Work  Do not Call Email: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

How did you hear about us?  Physician  Friend/Family  Website  Yellow Pages  Other \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

### Primary Insurance

Insurance Name: \_\_\_\_\_ Subscriber ID#: \_\_\_\_\_

Relationship to primary insured:  Self  Spouse  Dependent

If not self list Subscriber Name Last: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Plan Name: \_\_\_\_\_ Group #: \_\_\_\_\_

### Secondary Insurance

Insurance Name: \_\_\_\_\_ Subscriber ID#: \_\_\_\_\_

Relationship to secondary insured:  Self  Spouse  Dependent

If not self list Subscriber Name Last: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Plan Name: \_\_\_\_\_ Group #: \_\_\_\_\_

### Worker Comp/Auto

Insurance Company: \_\_\_\_\_ Claim #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Adjusters Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ (WC) Employer at time injured: \_\_\_\_\_

I understand that I am responsible for all fees regardless of insurance coverage. I am responsible for providing correct insurance information prior to treatment including changes in insurance coverage. I authorize Skyline Physical Therapy to provide evaluation and treatment that are medically necessary.

Signature \_\_\_\_\_ Date \_\_\_\_\_