Skyline PHYSICAL THERAPY

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: _____

Preferred Phone: _____ ❑ Cell ❑ Home ❑ Work Email: _____

Alternate Phone: _____ ❑ Cell ❑ Home ❑ Work

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 _____