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

Referring Provider: _____

How did you hear about us? ❑ Physician ❑ Friend/Family ❑ Website ❑ Other _____

Employer Name:_____ Occupation: _____ Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship: _____

Phone: _____

Primary Insurance

Insurance Name: _____ Subscriber ID#: _____

Plan Name: _____ Group #: _____

Relationship to primary insured: ❑ Self ❑ Spouse ❑ Dependent If not self list:

Subscriber Name Last: _____ First: _____ DOB: _____

Secondary Insurance

Insurance Name: _____ Subscriber ID#: _____

Plan Name: _____ Group #: _____

Relationship to secondary insured: ❑ Self ❑ Spouse ❑ Dependent If not self list:

Subscriber Name Last: _____ First: _____ DOB: _____

Worker Comp/Auto

Insurance Company: _____ Claim #: _____

Address: _____ City: _____ State: _____ Zip: _____

Adjusters Name: _____ Phone: _____

Date of Injury: _____ (**WC)** Employer at time injured: _____

Legal Representation: _____ Phone: _____

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 _____

1408 N Garden Street, Bellingham, WA 98225; (360) 738-4300; fax: (360) 738-8010