**MOUNTAIN2CITY PHYSICAL THERAPY, PLLC**

# REGISTRATION FORM

(Please Print)

| Today's date: | PCP: |
|---|---|

## PATIENT INFORMATION

| Patient's last name: | First: | MI: | Birthdate: |
|---|---|---|---|

| Street address: | City: | State: | Zip Code: |
|---|---|---|---|

| Marital status (circle one)<br>Single / Married / Other | Sex:<br>❑ Male ❑ Female | Primary phone no:<br>( ) | Alt. phone no.:<br>( ) |
|---|---|---|---|

| Email address: | Employer: |
|---|---|

| Referring provider: | Address: | Phone no.:<br>( ) |
|---|---|---|

## INSURANCE INFORMATION

(Please provide a copy of your insurance card.)

| Primary Insurance: | ID #: | Group #: |
|---|---|---|

| Subscriber's name: | Birthdate:<br>/ / | Sex:<br>❑ Male ❑ Female | Phone no.:<br>( ) |
|---|---|---|---|

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

| Customer service phone no.:<br>( ) | Insurance billing address: | Employer: |
|---|---|---|

| Name of secondary insurance (if applicable): | ID #: | Group #: |
|---|---|---|

| Subscriber's name: | Birthdate:<br>Sex: ❑ M ❑ F | Insurance billing address: | Customer service phone no.:<br>( ) |
|---|---|---|---|

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

## IF ACCIDENT RELATED:

| Date of accident: | How it happened:<br>❑ Work ❑ Auto ❑ Other ________________ |
|---|---|
| Insurance company: | Claim #: |

| Address: |
|---|

| Claims adjuster: | Phone no: |
|---|---|
| Attorney: | Phone no: |

## IN CASE OF EMERGENCY

| Name of local friend or relative: | Relationship to patient: | Primary phone no.:<br>( ) |
|---|---|---|

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Mountain2city Physical Therapy, PLLC or insurance company to release any information required to process my claims.

_______________________________________ ______________________

*Patient/Guardian signature* *Date*