**Gillette Physical Therapy - Patient Registration**

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| **Please Complete All** | | | | | | | | | | | | | Date  / / | | | | | | Therapist | | |
| Patient Name Last First Initial | | | | | | | | | | | | | | | | Marital Status  □ S □ M □ D □ W | | | | | Sex  □ M  □ F |
| Home Address | | | | | | | | | City, State, Zip | | | | | | | | | Telephone | | | |
| Occupation | | Social Security Number | | | | | | Date of Birth  / / | | | Age | | | Email (providing gives approval to receive information) | | | | | | | |
| Spouse or Parent Name | | | | Employer’s Name and Address | | | | | | | | | | | | | | Work Telephone | | | |
| Name of Financially Responsible Person (if Different from Patient) **MUST BE PERSON SIGNING FORM**  □ Spouse □ Parent □ Other | | | | | | | | | | | | | | | | | | | | | |
| Address (if Different from Patient) | | | | | | | | | | | | Date of Birth | | | | | | Social Security Number | | | |
| Employer Name and Address | | | | | | | | | | | | Telephone | | | | | | Work Telephone | | | |
| If Minor, name of other parent: | | | | | | | | | | | | | | | | | | | | | |
| Address of other parent: | | | | | | | Date of Birth | | | | | | | | Social Security Number | | | | | | |
| Employer Name and Address | | | | | | | Telephone | | | | | | | | Work Telephone | | | | | | |
| Primary Health Insurance Co. Name | | | | | | | Policy Holder | | | | | | | | Policy Holder's Relationship to Patient  □ Self □ Spouse □ Parent □ Other | | | | | | |
| Insurance Co. Address (not necessary if card was copied) | | | | | | ID/Policy No. | | | | Group No. | | | | | Policy Holder DOB | | | | | Effective Date  / / | |
| Secondary Health Insurance Co. Name | | | | | | | Policy Holder | | | | | | | | Policy Holder's Relationship to Patient  □ Self □ Spouse □ Parent □ Other | | | | | | |
| Insurance Co. Address (not necessary if card was copied) | | | | | | ID/Policy No. | | | | Group No. | | | | | Policy Holder DOB | | | | | Effective Date  / / | |
| **Emergency Contact** | | | | | **Relationship to Patient** | | | | | | | | | | | | | **Telephone** | | | |
| Your Current Problem:     Work Related? □ Yes □ No      Auto Accident? □ Yes □ No      Other Accident? □ Yes □ No | | | | | | | | | | | | | | | | | | | | | |
| **Date of Injury/Accident**  **/ /** | **Brief description of accident: (Where you were? How it happened?)** | | | | | | | | | | | | | | | | | | | | |
| Employer at Time of Injury | | | Address | | | | | | | | | | | | | | | Telephone | | | |
| Description of Injury: | | | | | | | | | | | | | | | | | | | | | |
| Workers’ Compensation Insurance Carrier (Please note that we accept Wyoming Worker’s Compensation ONLY) | | | | | | | | | | | | | | | | | Claim Number | | | | |
| If you are providing motor vehicle or worker’s compensation for payment, please provide your private health information to be filed in the event payment is not received by the motor vehicle insurance or if worker’s compensation gives a final denial on the claims. | | | | | | | | | | | | | | | | | | | | | |

AUTHORIZATION AND RELEASE:

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to my attorney, third party payers, and/or other health practitioners**. I authorize and request my insurance company to pay Gillette Physical Therapy directly for services rendered and billed by them.** I understand that the filing of insurance claims is a courtesy of Gillette Physical Therapy. I remain fully responsible for any charges incurred. I further agree that understanding my insurance benefits is my responsibility. Should I have any questions regarding my insurance my best avenue is calling my insurance company benefits department. I agree to be fully responsible for any fees incurred to collect any outstanding balance up to and including interest charges (up to 10%) and any court/sheriff fees used in attempt to collect any overdue debt. I understand that payment of copays/coinsurance may be requested to be paid prior to the full processing of my insurance claims. I authorize for detailed messages to be left on the phone numbers provided, unless noted otherwise. I further understand that the issuing of credit pending insurance payment is a courtesy and at the full discretion of Gillette Physical Therapy as payment is expected at the time service is rendered.

Signature of Patient/Legal Guardian if Minor Date