7340 W. 21st St. N., Suite 100 Wichita, KS 67205
Phone: (316) 613 - 3068 Fax: (316) 613 - 3774
www.premier-physical-therapy.net

Premier Physical Therapy Registration Form

Please Use Blue or Black Ink

Demographics

First Name _____ MI _____ Last Name _____

Date of Birth _____/_____/_____ SSN _____ - _____ - _____ Gender M / F Marital Status S / M / W / D

Address _____ City _____ Zip _____ -_____

Primary Phone: H _____ C _____ W _____

Email _____ How did you hear about us: _____

Employer:_____ Occupation: _____ Appointment Reminder? Text and/or Email

Emergency Contact: _____ Relationship _____ Phone # _____

Responsible Party

(who statements will be sent to)

□ Patient is the Responsible Party

First _____ MI _____ Last _____ SSN _____ - _____ - _____

Address _____ City _____ Zip _____ - _____

Relationship to Patient _____ Phone # _____

Insurance Information

Primary Ins _____ Member # _____ Group # _____

□ Patient is the policy holder If not,.. Policy Holder's First _____ MI ____ Last _____

DOB _____ / _____ / _____ SSN _____- _____ - _____ Employer _____

Address _____ City _____ Zip _____ - _____

Relationship to Patient _____ Phone # _____

Secondary Ins _____ Member # _____ Group # _____

□ Patient is the policy holder If not,.. Policy Holder's First _____ MI ____ Last _____

DOB _____ / _____ / _____ SSN _____- _____ - _____ Employer _____

Address _____ City _____ Zip _____ - _____

Relationship to Patient _____ Phone # _____

Injury, Motor Vehicle Accident (MVA), or Work Comp (WC)

Date of Injury/Accident _____ /_____ /_____ State it Occurred _____

Where did the injury occur? Work / School / Home / MVA / Other _____

If a MVA or WC,.. Claim # _____ Adjustor _____

Insurance Company _____ Phone # _____

HIPPA Information and Approval

- I agree to allow the release of medical or other information to process claims.
- I agree to accept assignment of payment. Determined by my current insurance policy.
- I give your office permission to leave a message on my answering machine.
- I give your office permission to discuss my medical condition with another medical professional.
- I have had the opportunity to read and request a copy of the Notice of Privacy Practices for this office.

Signature _____ Date _____/_____/_____

Patient or Parent/Guardian (if minor)