Physical Therapy Center

45A Washington Ave
CARTERET, NJ 07008

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Mr. Mrs.	Miss Ms.	Marital Status(circle one): Single / Mar/ Div / Sep / Wid

Is this your legal name? Yes No	If not, what is your legal name?	Social Security No:	Birth Date: / /	Age:	Sex: M F

Street Address:	Home Phone No.: ( )	Cell Phone No.: ( )

P.O Box:	City:	State:	Zip Code:

Occupation:	Employer:	Employer Phone No.: ( )

Chose clinic because/Referred to clinic by (please check one box):	Dr.	Insurance Plan

Hospital	Family	Friend	Close to home/work	Yellow Pages	Other:

Email Address:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Person responsible for the bill:	Birth Date: / /	Address (if different):	Home Phone No.: ( )

Is this person a patient here?	Yes	No	Occupation:

Employer:	Employer Address:	Employer Phone No.: ( )

Is this patient covered by insurance?	Yes	No

Please indicate Primary Insurance:

Subscriber's name:	Subscriber's S.S. No.:	Birth Date: / /	Policy Number	Co-Payment: $

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

IN CASE OF EMERGENCY

Name of a local friend or relative (not living at the same address):	Relationship to patient:	Home Phone No:	Work Phone No:

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 Carteret Physical Therapy or insurance company to release any information required to process my claims.

Patient/Guardian Signature:	Date: