

Smooth Moves PT: Patient Registration

Today's Date _____

Patient _____
Last Name First Name Middle Initial
Date of Birth _____ Age _____ Sex _____
Mailing Address _____
City, State, Zip Code _____
Phone Home: _____ Cell: _____ Work: _____
Email Address _____

Employer _____ Occupation _____
Business Address _____

Spouse or Parent (please circle one) _____
Address _____
City, State, Zip Code _____

Emergency Contact other than Spouse _____
Address _____
City, State, Zip Code _____ Phone _____

Referred By _____
Physician _____ Phone _____ Fax _____

Is Condition to be Treated due to: On the Job Injury? _____ Auto Accident? _____

Name of Insurance to be Billed _____
Patient's relationship to insured: Self Spouse Child Dependent
Name of Subscriber _____ Date of Birth _____
Subscriber ID# _____ Group # _____
Insurance Company Address _____
City, State, Zip Code _____ Phone _____
For on the Job Injury: Claim Number _____ Is Claim Currently Open? _____
Claim manager _____ Phone _____
For Auto Accident: Date of accident _____
Name of auto insurance company _____ Policy Number _____
Adjuster/Claim Manager Name _____
Claim Number _____
Attorney's Name _____

- I authorize the release of any medical records or other information necessary to process this claim.
- I authorize payment of medical benefits to Smooth Moves Physical Therapy
- I am financially responsible for any balance due.

Signed _____ Date _____