Integrated Physical Therapy, Inc.
20815 N 25th Pl, Suite 100, Phoenix, 85050 Phone: 602-374-2670 Fax: 602-354-8184

REGISTRATION FORM / PATIENT INFO

Date:_____ Home Phone:_____ Cell. Phone: _____

PATIENT INFO

Last Name:_____ First :_____ Initial: _____ SS#:_____
Address: _____
City: _____ State: _____ Zip Code:_____ Date of Birth: _____
Age: ___ Sex: ◯M ◯F Status: ◯Single ◯Married ◯Widowed ◯Separated ◯Divorced
Employed by: _____ Occupation:_____
Business Address: _____ Phone: _____
Referring Physician:_____
In case of emergency, who should we notify?_____Phone:_____

PRIMARY INSURANCE

Person responsible for account: Last Name: _____First: _____ Initial: ___
Relation to patient: _____ Date of Birth: _____ SS#: _____
Address (If different from patient's)_____
Phone:_____ City: _____ State: _____ Zip Code:_____
Person responsible employed by: _____ Occupation: _____
Business Address: _____ Phone: _____
Insurance Company: _____ Contract # : _____
Group No: _____ Subscriber #: _____
Names of other dependents under this plan: _____

Present your Ins. Card Please - don't fill this part

ADDITIONAL INSURANCE

Is Patient covered by additional insurance?: ◯Yes ◯No
Subscriber Name: _____ Relation to patient: _____
Date of Birth: _____ Address (If different from patient's):_____
_____ City: _____ State: _____ Zip Code: _____ Phone:_____
Subscriber Employed by: _____ Phone: _____
Insurance Company: _____ Group: _____ Subscriber #: _____
Names of other dependents under this plan:_____

Present your Ins. Card Please - don't fill this part

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with (Name of Insurance Company/ies): _____ and assign directly to Jeffrey Lee Eaton, MPT and/or Integrated Physical Therapy all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the Physical Therapist's office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____
Relationship: _____ Date: _____