New Patient Registration & Personal Information

Last Name/First Name: _____

Address: _____Apt.:_____

City: _____State: _____Zip Code: _____

Home Phone: _____Work: _____ Cell: _____

E-mail: _____

Referring Physician: _____

Social Security No.: _____Marital Status: ___Married ___Single

Sex: ___Male ___Female Date of Birth: _____Referred By: _____

In case of emergency contact: _____Phone #: _____

Insurance Information:

Name of Insured: _____ Policy#: _____

Insurance Carrier: _____Phone#: _____

Relationship to Insured: ____Self ____Spouse ____Child/Financial Dependent Date-of-Birth __/__/__

Responsible Party (if different from above): _____Phone: _____

Employment Information:

Employer: _____

Address: _____

I hereby assign all rights, privileges and remedies to payment of health care services to Fernando Moreno Physical Therapy, LLC. I also authorize Fernando Moreno Physical Therapy, LLC, having treated me, to release to government agencies, insurance carriers and all other who are financially liable for my case, all information needed to substantiate payments for care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment. I have read and understand the privacy practices of the office.

Patient Signature: _____Date: _____