CLIENT REGISTRATION FORM

Please **print clearly** and sign below:

Any Physical Therapy this year? Yes_____ No_____ Birth Date _____ Age _____

(Last)_____(First)_____(MI)_____

Billing Address _____ Physical Address _____

City_____ State _____ Zip _____

Drivers Lic # _____ Last 4 Digits of SSN # _____ Sex: F_____ M _____

Home Phone (_____)_____ Work Phone (_____)_____Cell Phone (_____)_____

How do you prefer to receive your statements: E-mail Fax Mail

E-mail _____Fax (_____)_____

Employer _____ Occupation: _____

How did you hear of BodyPro? Doctor Friend Patient Facebook Internet Instagram Ad

Referring Physician_____ Phone (_____)_____

Marital Status: Single Married Divorced Widowed Separated Domestic Partner Minor Child

Name of Spouse: _____ Age: _____ Birth date: _____

Address: _____ City: _____ State: _____ Zip: _____

Spouse Employer: _____ Occupation:_____

Work Phone: (_____)_____ Cell Phone: (_____)_____

Name and address of closest relative (other than spouse) in case of emergency:

Emergency Contact: _____ Relationship: _____ Phone: (____)_____

Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION (Please Complete)

Medicare ☐ Medicaid ☐ Worker's Comp ☐ VI ☐ SA ☐ st O ☐ Private Insurance ☐

Primary Insurance _____ Policy # _____

Insured Name _____ Social Sec# _____-____-_____ D.O.B. ___/___/____

Secondary Insurance _____ Policy # _____

Insured Name _____ Social Sec# _____-____-_____ D.O.B. ___/___/____

All professional services rendered are the ultimate responsibility of the patient.

Patient Signature: _____ Date: _____